

Health Care Financing



Status Report

Research and Demonstrations in Health Care Financing

April 1984 Edition

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Health Care Financing Administration

Health Care Financing

Status Report

The Office of Research and Demonstrations (ORD), Health Care Financing Administration (HCFA), directs more than 300 research, evaluation, and demonstration projects. A central focus is on program expenditures as they relate to reimbursement, coverage, eligibility, and management alternatives under Medicare and Medicaid. Study activity also examines program impact on beneficiary health status, access to services, utilization, and out-of-pocket expenditures. The behavior and economics of health care providers and the overall health care industry are also topics of investigation.

These activities are carried out by two major components—the Office of Research and the Office of Demonstrations and Evaluations. The Office of Research conducts and supports data collection efforts and research on health care providers, reimbursement, beneficiary behavior, and health care utilization. The Office of Demonstrations and Evaluations funds, manages, and evaluates pilot programs that test new ways of delivering and financing Medicare and Medicaid services.

This report provides basic information on active intramural and extramural projects in a brief format. These projects are used to assess new methods and approaches for providing quality health care while containing costs, and they often provide the basis for making critical policy decisions on health care financing issues.

Projects are arranged according to ORD budget priority areas and subject categories. The synopsis on each project includes the title, project number, project period, name of contractor or grantee organization, Federal project officer with primary responsibility for the project, a brief description, and the status of the project as of December 31, 1983. When a project involves research and development funds, the total funding amount for the life of the project is included. Remaining extramural projects are being conducted with waivers that permit innovations to financing and delivery of health services under the Medicare and Medicaid programs.

This is the third edition of the *Status Report*. Updated editions will be produced on a semi-annual basis. The information presented should be of use to policy officials, health planners, and researchers in examining the range of research and demonstration activities that are undertaken by ORD and the implications of results and findings.

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Health Care Financing

Status Report

Research and Demonstrations
in Health Care Financing

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations
Baltimore, Maryland
April 1984

Anne
Elizabeth
Taylor
Vaneke

Office of Research and Demonstrations

Bryan R. Luce, Ph.D., Director

Steven A. Pelovitz, Deputy Director

Office of Research

Allen Dobson, Ph.D., Director

Office of Demonstrations and Evaluations

Al Esposito, Acting Director

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HOSPITAL PAYMENT

Inpatient General

Valid and Reliable Measurement of Inappropriate Hospital Utilization

Project No.: HCFA 500-80-0053
Period: June 1980 - September 1983
Funding: \$ 950,406
Contractor: SysMetrics, Inc.
104 West Anapamu Street
Santa Barbara, Calif. 93101
Project Officer: Sherry A. Terrell
Division of Beneficiary Studies

Description: The purpose of this project is to study inefficient acute care hospital utilization. The study has two components:

- The development of a methodology for measuring inappropriate hospital utilization.
- The application of the method in a national study to estimate the magnitude of inappropriate utilization and to identify likely causal factors. A (patient) chart review methodology was applied in 253 general acute care hospitals across the United States. Estimates of inappropriate admissions and days of care were made.

Status: This project is complete, and a draft final report was received in February 1984. In 1981, a total of 1,925,000 or 5.7 percent of all admissions to acute care hospitals, excluding pediatrics and normal deliveries, were estimated to be nonacute. A total of 30,066,000 days or 12.0 percent of all days, were found to be nonacute. Of these days, 4.2 percent were unnecessary because the admissions were unjustified, and 7.8 percent were unnecessary days that occurred in otherwise justified admissions. The final report included the standardized medical review instrument (SMI), the SMI field staff training manual, technical appendices including calculations of sampling weights, and the algorithm for the generalization of relative variance, data tapes, and file documentation.

Two unpublished reports from this project are entitled:

- "The Measurement of Nonacute Hospital Utilization in a National Sample: The Admission Model."
- "The Measurement of Nonacute Hospital Utilization: Factors Associated With Nonacute Days."

Hospital Costs and the Reduction of Excess Hospital Capacity

Project No.: 95-P-97526/5-02
Period: December 1979 - March 1984
Funding: \$ 270,000
Grantee: Michigan Office of Health and Medical Affairs
P.O. Box 30026
Lewis Cass Building
Lansing, Mich. 48909
Project: Joe Cramer
Officer: Division of Hospital Experimentation

Description: This project grew out of concerns of labor and industry organizations involved in paying for medical care. By eliminating excess hospital beds, health care costs could be reduced. A Governor's task force was formed to address the financial, legal, and employment-related issues involved in hospital closures. Legislation was passed to require the development of bed-reduction plans. It is anticipated that 3,800 acute care hospital beds will be eliminated over the life of the program. Under the demonstration, the Michigan Hospital Capacity Reduction Corporation (HCRC) will review proposals from hospitals and approve specific reimbursement waivers related to capacity reduction activities. All third-party payers are expected to participate.

Status: Six health systems agencies with excess beds developed hospital-specific, bed-reduction plans that are updated on an ongoing basis. A Hospital Capacity Reduction Corporation was established in January 1981 to facilitate hospital capacity reduction. The Health Care Financing Administration recently approved, for 1 year, Michigan's request to consider waivers of selected Medicare reimbursement policies on a project-by-project basis to facilitate hospital capacity reduction. Michigan accepted all of HCFA's terms and conditions. HCRC finally approved its first bed-reduction application for costs associated with the full closure of New Plymouth Road General Hospital. HCFA has tentatively agreed to participate in the project.

Reducing Inappropriate Use of Inpatient Medical Surgical and Pediatric Services--Extension of the Appropriateness Evaluation Protocol

Project No.: 18-P-98317/1-01
Period: May 1983 - January 1985
Grantee: University Hospital, Inc.
75 East Newton Street
Boston, Mass. 02118
Project: Sherry A. Terrell
Officer: Division of Beneficiary Studies

Description: The purpose of this grant is to revise the Appropriateness Evaluation Protocol (AEP) to deal with two concerns: the problem of surgical admissions which should be performed on an outpatient basis and the problem of indications for performance of surgical procedures. The grantee will also conduct a formal experimental trial of the effectiveness of educational feedback of AEP results to hospital administrators and physicians upon lowering levels of inappropriateness.

Status: This project has begun to modify the admission criteria, revise the AEP instrument, train reviewers, and recruit hospitals. In addition, a survey of 12 organizations has been conducted to identify the ambulatory surgical procedures. Lists of indications for common inpatient elective procedures such as cholecystectomy, hysterectomy, and appendectomy have been completed. Data collection has been delayed because of peer review reorganization of responsibilities.

Pediatric Appropriateness Evaluation Protocol Instrument

Funding: Brandeis University Health Policy Consortium
(See page 132)
Project Officer: Sherry A. Terrell
Division of Beneficiary Studies

Description: One of the projects conducted by the University Health Policy Consortium was to adapt the Appropriateness Evaluation Protocol (AEP), originally designed for review of adult medical and surgical admissions and days of care, to the needs for pediatric review. The principle instrument revisions made were to strengthen the admission criteria to account for special pediatric admission problems such as failure to thrive and child abuse. In addition, the criteria for an appropriate day in the hospital, although similar to those utilized for adults, were modified to account for physiologic differences between adults and children. As an example, normal values for lab tests, blood pressure, and temperatures were modified to reflect pediatric norms. The instrument applies to children 2-15 years of age and is not intended for review of neonatal care.

Status: Following instrument revision, the Policy Center conducted a set of methodological trials to assess the reliability and utility of the AEP/PED. A field trial was completed using the AEP/PED on Medicaid pediatric admissions in the Metropolitan Boston area. The Health Care Financing Administration has received the following products: the AEP/PED 83 instrument, training manual instructions, and a final report in February 1984. The documents will be available through the National Technical Information Service.

Public General Hospitals: Costs and Case Mix

Funding: Intramural
Project J. Michael Fitzmaurice
Director: Division of Reimbursement Studies

Description: Public general hospitals (PGH's) are often the health care "providers of last resort" for patients who cannot afford to pay for their hospital care and are not covered under Medicaid. Because of this special role, public general hospitals frequently incur costs which do not receive direct reimbursement for services provided to many of their (poor) patients. Tax-financed subsidies often come from the State or local governments that have jurisdiction over these hospitals, but the hospitals' patient care costs may not be fully covered by these subsidies. This leads to public hospital expenses being greater than revenues and to reduced access to hospital care for part of the population. In the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Congress directed the Secretary, Department of Health and Human Services, to consider the "special needs" of hospitals "that serve a significantly disproportionate number of patients who have low income or are entitled to benefits" under Medicare in the application of the Section 101 total operating expense per case limits. In addition to TEFRA, there is also a concern over the level of rates with which PGH's would be faced under the Medicare prospective payment system. As part of considering the "special needs" of PGH's, this study will examine the Medicare cost reports of public general hospitals to determine if their costs are higher than the costs of other short-term general community hospitals and other hospitals with the same characteristics as PGH's, other than public ownership. The Medicare case-mix indices of these hospitals and the number of exceptionally long-stay cases will also be examined to see if there is any evidence that PGH patients have measurably higher case complexities.

Status: The data base for this study is the 1980 Hospital Medicare Cost Report File, the 1980 Medicare Case-Mix Index File, and the 1981 Office of Civil Rights Hospitals Survey. These files have been linked, edited, and expanded to include the 1981 hospital cost and case-mix data. Analysis of this data has begun and a draft report of this study is expected to be completed in June 1984.

Analysis of a Proposed Medicare Offset of Hospital Part B Losses With Surpluses Generated Under Part A

Funding: Intramural
Project J. Michael Fitzmaurice
Director: Division of Reimbursement Studies

Description: This study examines the potential effects of a proposal for eliminating two regulatory adjustments:

- The provision for aggregate calculation of the lesser of costs or charges between inpatient (Part A) and outpatient (Part B) hospital services (rather than keeping the calculations separate between Part A and Part B hospital services).
- The provision allowing providers to carry forward unreimbursed costs (any negative sum of Part A plus Part B, cost minus charge differences) to subsequent years to a time when costs exceed charges.

Status: This study reveals that, in 1980, 20 percent (196) of a sample of 984 hospitals used an excess of inpatient charges over costs to offset outpatient losses (charges less than costs). The range of these offsets per hospital was from \$125 to \$4.5 million. For the sample, the estimated cost to the Medicare program in 1980 was \$28 million. The groups of hospitals with the largest mean offsets were those having a larger number of beds, nonprofit or government type of control, a location out of the North Central region, a location in standard metropolitan statistical areas, and teaching status. A final report was received April 1983. An addendum is being prepared to clarify the proposed regulatory adjustments and to provide an update on the estimates. This addendum is expected in April 1984.

Analysis of Medicare Routine Costs Under Alternative Assumptions

Funding: Intramural
Project J. Michael Fitzmaurice and Stuart Guterman
Directors: Division of Reimbursement Studies

Description: This project grew out of a request from the Bureau of Eligibility, Reimbursement, and Coverage, Health Care Financing Administration to examine the level of Medicare routine costs per day under alternative assumptions about the counting of labor (and false labor) room days as routine costs days. Additionally, the influence of obstetrical room days on the level of routine costs is to be investigated.

Status: This study will use published data from the Commission on Professional and Hospital Activities, Hospital Administrative Services, the American Hospital Association, and information derived from hospital Medicare cost reports. The hypothesis that excluding labor room days from the calculation of routine costs per day will increase the routine costs per day will be investigated. Further, the hypothesis that excluding the costs of obstetrical room days from the costs of all other general service routine patient days (they are currently averaged together) will reduce routine costs per day, will be examined. A report is expected on this project in Spring 1984.

Outpatient

Physician and Other Ambulatory Services in Hospitals: Costs and Determinants

Project No.: 18-P-97880/5
Period: April 1981 - March 1984
Funding: \$ 348,318
Grantee: American Hospital Association
840 North Lake Shore Drive
Chicago, Ill. 60611
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: This ambulatory care project involves the collection and analysis of a large and significant data set that is expected to be the first in a recurring survey of hospital ambulatory care. The analysis is expected to provide a context for better understanding of the costs of hospital-based ambulatory care. The data will facilitate describing and monitoring costs of services in hospital outpatient departments.

Status: The American Hospital Association's first major submission under this grant was the refined analytical design submitted in October 1981. The survey design required several iterations because outpatient department cost data is not typically recorded in disaggregate detail by most hospitals. Surveying began in November 1982. Special followup efforts to enhance response rates have been prepared for public hospitals, urban hospitals, teaching hospitals, and hospitals with more than 300 beds. A final report is due in Spring 1984.

Comparison of Services in Hospital Outpatient Departments and Physician Offices

Project No.: 500-83-0037
Period: September 1983 - March 1984
Funding: \$ 37,104
Contractor: Mandex, Inc.
8302 D Old Courthouse Road
Vienna, Va. 22180
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: This study analyzes data developed under a prior study of services that are commonly performed in either physicians' offices or hospital outpatient departments. The study will identify the character and scope of physicians' services used by Medicare patients in hospital outpatient settings, and compare the array of laboratory, pathology, and radiology (diagnostic) procedures associated with specific treatment procedures that are provided in an office as opposed to a hospital outpatient setting.

Status: Continued development and refinement of data from the South Carolina and/or other carrier are currently being carried out. A selection process for the appropriate physician-provider identification is being developed. Once this is completed, data from additional carrier files will be merged to produce a data base suitable for analysis.

Development of an Ambulatory Patient Classification System

Project No.: 18-P-98361/1-01
Period: September 1983 - September 1985
Funding: \$ 713,404
Grantee: Yale University
320 York Street
New Haven, Conn. 06520
Project Officer: John T. Petrie
Division of Reimbursement Studies

Description: This study will develop an outpatient classification system to define a manageable number of patient categories that have similar patterns of resource use. The classification will take into account the spectrum of resources used to deliver ambulatory care. The unit of analysis will be the patient visit rather than an episode of illness. Clinicians will review the grouping of patients that will be suggested by statistical methods. The classification will apply to items over which physicians have control, that is, diagnostic tests and treatment associated with a given visit. Yale will then evaluate the resolution, constancy, and predictive performance of the ambulatory classification.

Status: The project began November 1, 1983, and no preliminary results are available.

Case Mix and Resource Use in Hospital Emergency Room Settings

Project No.: 18-P-98310/9-01
Period: March 1983 - March 1985
Funding: \$ 440,193
Grantee: University of California
School of Public Health
405 Hilgard Avenue
Los Angeles, Calif. 90024
Project Officer: John T. Petrie
Division of Reimbursement Studies

Description: The purpose of this study is to develop a patient classification scheme and case-based cost control system for hospital emergency room settings. Such a system might provide the Health Care Financing Administration (HCFA) with the foundation for reimbursing hospitals on a case-mix basis for the treatment of emergency room patients. This project will also study overall potential for case-based reimbursement for all components of hospital-based ambulatory care. The grantee will address two main issues important to HCFA in understanding and controlling hospital costs:

- The growth in the use of hospital-based ambulatory care services and how they relate to inpatient hospital services.
- The creation of fair and equitable incentives for cost containment.

Status: Because of staffing problems, this project did not begin until June 30, 1983.

Development of a Case-Mix-Based Reimbursement Method for Hospital Outpatient Departments and Freestanding Clinics

Project No.: 18-P-98300/1-02
Period: March 1983 - March 1986
Funding: \$ 790,108
Grantee: Brandeis University
Florence Heller Graduate School
Waltham, Mass. 02139
Project Officer: John T. Petrie
Division of Reimbursement Studies

Description: The purpose of this grant is to provide accurate case-mix and patient socioeconomic data about visits to hospital outpatient departments (OPD's) and freestanding clinics. The grantee will develop a case-mix-based methodology, similar to the diagnosis-related groups (DRG's), which the Health Care Financing Administration can use to reimburse hospital OPD's. They will provide policymakers with information on the special situation of hospital OPD reimbursement, and investigate why the same visit to a hospital OPD can cost twice as much as a visit to a physician in private practice. Their case-mix reimbursement system will be able to compare OPD's with each other with respect to medical and social differences in case load and then will allow OPD's to be reimbursed the same amount for patients of the same type.

Status: This project was initiated March 31, 1983, and no preliminary findings are available.

Prospective Payment

National Hospital Rate-Setting Study

Project No.: 500-78-0036
Period: August 1978 - August 1983
Funding: \$ 4,462,237
Contractor: Abt Associates, Inc.
55 Wheeler Street
Cambridge, Mass. 02138
Project Officer: Richard Yaffe
Evaluative Studies Staff

Description: This is the evaluation of the impact of 15 hospital prospective reimbursement programs from 1970 to 1979. The study focuses on the following eight areas:

- Cost/Revenue/Financial Viability.
- Volume and Composition of Services.
- Staffing and Labor Cost.
- Quality of Care and Ancillary Intensity.
- Capital Formation and Closure/Merge Rates.
- Organization and Management.
- Accessibility of Care.
- Systemwide Cost and Utilization.

Status: The final results for each of the above listed areas will be available by July 1984.

Incentive Prospective Payment System for Hospitals Through Fiscal Intermediaries (Massachusetts)

Project No.: 95-P-98199/1-02
Period: September 1982 - September 1986
Grantee: Massachusetts Hospital Association
5 New England Executive Park
Burlington, Mass. 01803
Project Officer: Diane L. Rogler
Division of Hospital Experimentation

Description: This is a statewide, all-payer, prospective hospital reimbursement project proposed to Medicare by the Massachusetts Hospital Association and administered by Blue Cross of Massachusetts (BCM). The methodology utilizes a "maximum allowable cost" developed from the BCM 1981 base-year costs which are adjusted annually for inflation, volume changes, and certain other approved exceptions. Each year the amount paid to hospitals by Medicare and Medicaid is reduced by a 2-percent productivity factor. The Massachusetts Rate-Setting Commission approves each hospital's gross patient service revenue based on their review of BCM cost report and provides an oversight function. The rate of increase in Medicare hospital expenditures in Massachusetts is capped at the average rate of increased experienced by Medicare nationwide. If total Medicare hospital costs are less than 1.5 percent below the national average rate of increase, the hospitals will share in half of the savings.

Status: Implementation of the project began October 1, 1982. Currently, charges and payments from Blue Cross, Medicare, and Medicaid are based on the maximum allowable cost methodology with some methodological variations existing for each payer.

Rochester Area Hospitals' Corporation

Project No.: 95-P-97501/2-02
Period: January 1980 - December 1984
Grantees: State of New York/Rochester Area Hospitals' Corporation
Empire State Plaza Tower Building
Albany, N.Y. 12237
Project Officer: Vic McVicker
Division of Hospital Experimentation

Description: The Rochester Area Hospitals' Corporation (RAHC) Hospital Experimental Payment Program is a test of whether an areawide budget system will be effective in controlling hospital costs in a metropolitan area and whether local decisionmaking can effectively allocate financial resources between hospitals to cover the cost of new services. This 5-year project, which includes all third-party payers (Medicare, Medicaid, and Blue Cross), was initiated January 1, 1980, and includes nine hospitals in the Rochester area of New York. The Hospital Experimental Payment program places an upper limit or cap on the total revenue paid to the community's hospitals for all patient care. Each participating hospital's revenue for 5 years is guaranteed at a base level, calculated primarily from the hospital's 1978 costs, trended forward to reflect inflation. In addition, a 2-percent contingency fund is administered by RAHC to pay for increased hospital services and new and improved medical technology, and to provide working capital for participating hospitals.

Status: Based on an assessment of the first 3 years of operation, the hospitals and payers agreed to maintain the system for the entire 5-year test. As part of this assessment, a comparison of cost from 1978 to 1981 was made between Rochester and comparison hospitals in Buffalo and Syracuse.

- Cost per patient day increased 32.2 percent in Rochester, 45.8 percent in Buffalo, and 46.1 percent in Syracuse.
- Cost per admission increased 39.1 percent in Rochester, 44.7 percent in Buffalo, and 49 percent in Syracuse.
- Cost per emergency department visit increased 41 percent in Rochester, 67 percent in Buffalo, and 61 percent in Syracuse.
- Cost per outpatient clinic visit increased 20.5 percent in Rochester, 32 percent in Buffalo, and 23.8 percent in Syracuse.

The latest data on total Medicare hospital payments in Rochester show rates of increases of 11.9, 10.8, and 9.0 percents in 1980, 1981, and 1982; these figures are far below the national average growth in Medicare hospital payments.

Finger Lakes Area Hospitals' Corporation

Project No.: 95-P-97877/2-01
Period: January 1981 - December 1985
Grantee: Finger Lakes Area Hospitals' Corporation
One Franklin Square
Geneva, N.Y. 14456
Project: Vic McVicker
Officer: Division of Hospital Experimentation

Description: The Finger Lakes Area Hospitals' Corporation (FLAHC) is a test of whether an areawide budget system will be effective in controlling hospital costs in a rural area and whether local decisionmaking can effectively allocate financial resources between hospitals to cover the cost of new services. This 5-year project, which includes all third-party payers (Medicare, Medicaid, and Blue Cross), was initiated January 1981, and includes eight hospitals in the rural Finger Lakes area of New York. The FLAHC payment program places an upper limit or cap on the total revenue paid to the community's hospitals for all patient care. Each participating hospital's revenue for 5 years is guaranteed at a base level, calculated primarily from the hospital's 1979 costs, trended forward to reflect inflation. In addition, a 2-percent contingency fund is administered by FLAHC to pay for increased hospital services and new and improved medical technology, and to provide working capital for participating hospitals.

Status: Based on an assessment of the first 3 years of operation, the hospitals and payers agreed to maintain the system for the entire 5-year test. Changes in utilization and cost levels of the FLAHC hospitals during the first year of the project were compared with the corresponding changes for two sets of comparable hospitals, one group located in the Syracuse area and the other in Northeastern New York State. From 1980 to 1981, the inpatient cost per day rose 13.3 percent in FLAHC, compared with 13.5 percent for the Syracuse peer group, and 15.0 percent for the Northeastern peer group. Patient discharges dropped 6.1 percent in the FLAHC area, compared with drops of 1.9 percent for the Syracuse peer group and 1.1 percent for the Northeastern peer group. The most relevant cost measure--total inpatient cost--rose 11.4 percent in FLAHC, compared with 16.6 percent for the Syracuse peer group and 14.5 percent for the Northeastern peer group. Other measures of inpatient utilization and cost performance also showed a beneficial effect. From 1980 to 1982, total Medicare payments in the FLAHC program increased by 31.7 percent (22.4 percent occurred in the first year) compared with an increase of 40 percent nationwide. These payments were not adjusted by the estimated 6 percent increase in payments caused by a change in interim payment methodology. For the next 2 years, reimbursement will be limited to trend plus 2 percent; the payers' cost savings should be increased during this period.

Prospective Reimbursement System Based on Patient Case Mix for New Jersey Hospitals

Project No.: 600-77-0022
Period: December 1976 - December 1983
Funding: \$ 4,912,802
Contractor: New Jersey State Department of Health
CN 360
Trenton, N.J. 08625
Project Officer: Cynthia K. Mason
Division of Hospital Experimentation

Description: This project is testing a prospective payment system based upon diagnosis-related groups (DRG's). Each DRG contains diagnoses that require similar levels of resource consumption. Hospitals retain any savings if costs are less than the DRG rates, but they assume liability if expenditures are greater. All general acute care hospitals in the State are required to participate and the system is applicable to all patients as well as third-party payers.

Status: The Medicare and Medicaid waivers approved for the demonstration were to have expired on December 31, 1983. However, the regulations for Section 1886(c) of the Social Security Amendments for 1983, which provide for the continuation of State hospital payment programs, are not yet available. Therefore, the New Jersey demonstration waivers have been temporarily extended pending final publication of those waivers.

Proposal for the Development of a Hospital Reimbursement Methodology for New York State for the 1980's

Project No.: 95-P-98216/2-01
Period: January 1983 - December 1985
Grantee: State of New York Department of Health
Empire State Plaza
Tower Building, Room 1043
Albany, N.Y. 12237
Project: Joe Cramer
Officer: Division of Hospital Experimentation

Description: The 3-year project is a test of a prospective per diem payment system for all payers in the State. Rates are determined using 1981 costs as the base. Base-year allowable costs are calculated through the use of peer group comparisons with ceilings on ancillary costs and a combined routine cost/length-of-stay ceiling. Once allowable costs were determined, rates for 1983 were calculated by inflating the costs by a trend factor. In 1984 and 1985, a "rate-to-rate" methodology is applied. The system provides for the establishment of bad debt and charity care pools on a regional basis to be supported by the payers.

Status: The methodology and efficiency standards used to establish the 1981 allowable cost base, which were used to establish the 1983 rates and will be used to establish the 1984 and 1985 inpatient revenue caps, were implemented. The mechanisms for making payments into the bad debt and charity care pools by the major third-party payers and the hospitals have been developed and implemented. The eligibility criteria and methodology for distributing funds have been established for these pools. The information necessary to implement the Medicare malpractice apportionment rules for the purpose of distributing malpractice costs among payers in the 1984 revenue caps is being collected. Finally the regulations implementing the system in 1984 and 1985 have been promulgated.

Prospective Payment System for Acute and Chronic Care Hospitals in Maryland

Project No.: 500-80-0044
Period: June 1980 - October 1983
Funding: \$ 2,037,563
Contractor: State of Maryland Health Services Cost Review Commission
201 West Preston Street
Baltimore, Md. 21201
Project Officer: Thomas A. Noplock
Division of Hospital Experimentation

Description: This project is testing the long-term effects of an all-payer, statewide hospital prospective payment system in Maryland. The Maryland Project uses a public utility commission's approach to hospital rate regulation. The Maryland Health Services Cost Review Commission established hospital rates and then adjusted them for such items as inflation, volume changes, and pass-through costs. Currently, Maryland employs three separate systems: a detailed budget review system for individual hospitals; an automatic annual inflation adjustment for individual hospitals without a total budget review; and a payment system based on diagnosis, the Guaranteed Inpatient Revenue system.

Status: The present Medicare and Medicaid demonstration waivers have been extended under the authority of Section 402 of the Social Security Amendments of 1967 until the regulations are promulgated for Section 1886(c) and the State's system has been considered under this new Medicare program waiver authority. For the Health Services Cost Review Commission (HSCRC) methodology to comply with the waiver continuation agreement, the HSCRC has approved regulations governing rates for hospital-based physician services. In addition, the rebundling provisions of the 1983 Social Security Amendments are being implemented in Maryland. This requires the hospital to bill under Medicare Part A for all nonphysician services provided to inpatients. A final report on the contract is expected in February 1984.

Case Mix

An Examination of the Case-Mix Length of Stay, Costs, and Reimbursement of Rural Hospitals

Project No.: 18-P-97703/702
Period: September 1980 - September 1982
Funding: \$ 184,318
Grantee: University of Iowa
Graduate Program in Hospital and Health
Westlawn Building
Iowa City, Iowa 52242
Project Officer: John T. Petrie
Division of Reimbursement Studies

Description: This research examines the performance of rural hospitals with an interest in determining the influence of case mix, patient referral patterns, and Medicare utilization on the costs, length of stays, and reimbursement in hospitals. The study examines discharge data using AUTOGRP case-mix methodology.

Status: Preliminary results indicate that rural hospitals transfer many of their more complex cases to urban hospitals. A final report is expected in April 1984.

Measuring the Cost of Case Mix Using Patient Management Algorithms

Project No.: 18-P-97063/3-05
Period: September 1978 - July 1984
Funding: \$ 1,166,846
Grantee: Blue Cross of Western Pennsylvania
One Smithfield Street
Pittsburgh, Pa. 15222
Project Officer: John T. Petrie
Division of Reimbursement Studies

Description: This project is developing and testing a case-type classification system for output measurement and hospital classification using clinical management criteria and category weights based on cost. Relative weights are being calculated for the categories based on the services that clinicians believe typical patients should receive. The project is also developing the capability to calculate alternative weights based on the services that the average patient actually receives as indicated by billed charges.

Status: The patient management categories (PMC's), the related computer decision rules, and the physician consensus of the PMC's will be completed by July 1984. Proximate patient management categories (which can be applied with current discharge abstract data), a comparison of the diagnosis-related groups and the PMC methods, and a method for adjusting cost weights for comorbid cases have already been completed. Current objectives include computerizing the comorbidity adjustment to the cost weights, analyzing deaths and related cost-weight adjustment methods, and analyzing case-mix changes for hospitals over time.

Capital

Medicare-Medicaid Payment Policies and Capital Formation

Project No.: 18-P-98267/1-01
Period: April 1983 - September 1984
Funding: \$ 274,805
Grantee: Center for Health Economics Research
822 Boylston Street, Suite 104
Chestnut Hill, Mass. 02167
Project Officer: Philip Cotterill
Division of Economic Analysis

Description: The objective of this project is to provide policymakers with new information on the effects of Medicare and Medicaid payment policies on hospital capital formation, past and future. First, there is a need to analyze the combined, overall effect of Medicare and Medicaid payment policies so that a policy can be designed that results in adequate, but not excessive, hospital investment in plant and equipment. Second, the project would analyze the impact of payment policies on hospital decisions to implement cost-saving or cost-inducing technologies. To complement these analyses, the following issues would be studied empirically:

- The effect of hospital dependence on Medicare and Medicaid revenues on hospital financial status and capital formation.
- The effects of alternative payment policies, especially prospective payment, on capital formation.
- The relationships between Medicare and Medicaid payment policies, hospital competition, and capital formation.
- The effects of public payment policies on hospital closures and mergers.
- The adoption of cost-saving or cost-inducing technology.

Data to be used in the project includes the Abt National Rate-Setting Medicare Cost Report file of 2,500 hospitals covering the period 1970-79. Parallel analyses will be conducted using American Hospital Association data for the period 1974-82. These files are operational currently. Some additional data will be collected for small pilot studies.

Status: The grantee has prepared a descriptive paper, "Treatment of Capital Costs in Four Medicare-Waivered States: Maryland, New Jersey, New York, and Massachusetts." A report on the first year's activities under the grant is expected by August 1984.

Data Development and Analyses

Automated Hospital Information Systems: Development of Evaluation Methods

Project No.: 18-P-97925/9-02
Period: January 1981 - September 1984
Funding: \$ 464,657
Grantee: Lutheran Hospital Society of Southern California
1423 South Grand Avenue
Los Angeles, Calif. 90015
Project Officer: William Damrosch
Division of Hospital Experimentation

Description: This 4-year project examined the ramifications of using various types of automated hospital information systems within the hospital. The sponsor has developed a methodology for establishing a cost-benefit analysis for the types of systems to be installed in various hospital settings.

Status: Three manuals have been completed that will enable hospitals to make informed judgments about the installation of an automated hospital information system. These manuals are entitled:

- "Guide to Automated Hospital Information System Selection: The Specification Process."
- "Software for Evaluating Automated Hospital Information Systems."
- "Benefits Optimization for Automated Hospital Information Systems."

Data for Hospital Cost Monitoring and Analysis of Hospital Costs

Project No.: 500-80-0066
Period: September 1980 - December 1984
Funding: \$ 931,800
Contractor: American Hospital Association
840 North Lake Shore Drive
Chicago, Ill. 60611
Project Officer: J. Michael Fitzmaurice
Division of Reimbursement Studies

Description: This project obtains survey data from a set of hospitals that are surveyed monthly about their costs and activities. This serves as a prime source of outside data on the performance of hospitals and is used in Health Care Financing Administration (HCFA) analyses, research, and publications.

Status: To date, HCFA has received monthly "National Hospital Panel Survey Reports" and monthly "Community Hospital Statistics" through September 1983. The data are available in both hard copy and computer tape format.

Statistical and Analytical Services to Support Provider Reimbursement Studies

Project No.: 500-78-0041
Period: September 1978 - December 1983
Funding: \$ 1,555,000
Contractor: Applied Management Sciences
962 Wayne Avenue
Silver Spring, Md. 20910
Project Officer: J. Michael Fitzmaurice
Division of Reimbursement Studies

Description: This is a project to provide statistical and analytical support for studies of hospital cost variation and hospital cost inflation. This includes simulations of models developed and directed by the Office of Research as well as a number of separate investigations, such as analysis of the influence of various payment systems on hospital cost behavior. With the support of the contractor, this project has been able to supplement existing Medicare hospital data bases with information targeted to specific program administration and policy research questions and to respond rapidly to the need for such research when necessary.

Status: Since July 1, 1983, two tasks have been assigned:

- Establish criteria for identifying and analyzing health claims processing systems with potential emergency use.
- Analyze hospital cost and utilization performance during the period 1978-80.

The contract is scheduled for completion in Spring 1984.

Financially Troubled Hospitals

Bedford-Stuyvesant/Crown Heights Demonstration Project

Project No: 95-P-97605/2-04
Period: November 1979 - May 1983
Grantee: New York State Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: The goal of the project was to achieve fundamental changes in the health care delivery system in the project catchment area. This 4-year demonstration project tests new reimbursement strategies formulated to provide for Federal coverage of a proportionate share of uncompensated care costs. The project tests whether financial stability promotes a reconfiguration of the delivery system and subsequent viability.

Status: System changes as part of the project were:

- Consolidation of the nonemergency ambulatory care currently provided by the hospitals under a separate corporation. (Certificate-of-Need application submitted October 1981.)
- Consolidation at Jewish Hospital and Medical Center of Brooklyn (JHMCB) of the obstetrical services currently provided by this hospital and St. John's. (Application submitted September 1981.)
- Full merger of JHMCB and St. John's with a combined reduction in beds of 245, from 945 to 700. (Application submitted May 1982 - beds since reduced to 650 complement.)

The merger application was approved by the New York State Public Health Council on November 19, 1982, thus completing the State approval process. A 6-month extension of the project was granted (November 26, 1982 through May 27, 1983) to facilitate the transition to standard payment methods. A final report is pending.

Metropolitan Comprehensive Care Program: A Health Systems Organization Demonstration

Project No.: 11-P-97805/2-04
Period: September 1980 - September 1986
Grantee: New York State Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: The demonstration is designed to test a new financing and health care role for municipal hospitals. The demonstration is specifically targeted for the medically indigent and all other members of the East Harlem community. A 5-year study which is based at Metropolitan Hospital will provide coverage to a maximum of 17,100 poor and near-poor residents of the community who are ineligible for Medicaid coverage under existing Federal/State regulations. The five critical components of the demonstration are:

- The case management system.
- The reorganization of the hospital management and financial systems.
- The introduction of the Citycaid program.
- Improved screening for Medicaid, Citycaid, and other third-party insurance.
- The establishment of a State qualified health maintenance organization (HMO).

Status: The focus of the first 3 years' activities was establishing administrative mechanisms and implementing organizational changes to support a case-management approach to medical care for an enrolled population. The fourth year will focus on the planning and development of an HMO. Enrollment levels have been growing. As of September 1983, the program had enrolled 5,542 in Citycaid, 3,985 Medicaid recipients, and 7,078 others.

Alternative Methodologies for Reimbursement and Delivery of Health Care Services to Inner City Poor

Project No.: 11-P-97863/1-03
Period: January 1981 - January 1984
Grantee: Massachusetts Department of Public Welfare
600 Washington Street
Boston, Mass. 02111
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: This 3-year demonstration project, the Boston Health Plan, tests the effectiveness of a case-management system in a network of Community Health Centers linked to an inner city hospital. Reimbursement is a prospective capitation method. The approach will demonstrate that:

- Financial viability can be achieved by the use of new "strategies" in the provision of patient care and methods of reimbursement.
- The hospital can serve as an effective case manager, reducing costs and improving health outcomes.

Status: The project became operational November 1, 1981, and six primary care centers were providing services by February 1983. As of December 1, 1983, the centers had enrolled 9,240 newly eligibles, 1,180 city employees, and 784 currently eligible Medicaid recipients. The grant terminated on January 15, 1984, and the final report is due in April 1984.

Strategies to Improve the Financial Viability of the Urban Hospital

Project No.: 11-P-97866/4-04
Period: January 1981 - September 1984
Grantee: Florida Department of Health and Rehabilitative Services
1317 Wiscewood Boulevard
Tallahassee, Fla. 32301
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: This 4-year demonstration project will test the feasibility of covering a medically needy population in Florida in a capitated primary care system. Enrollees will lock themselves into care at an urban hospital and its primary care center. The services provided are limited to inpatient, outpatient, physician services, and pharmacy. The approach will demonstrate that:

- Financial viability can be achieved by the use of new "strategies" in the provision of patient care and methods of reimbursement.
- The hospital can serve as an effective case manager, reducing costs and improving health outcomes.

Status: The project became operational October 1, 1981, with the opening of a new primary care center at the University Hospital of Jacksonville. As of July 1, 1983, there were 15,988 enrollees at the center--6,000 newly eligibles, 4,048 currently eligible Medicaid recipients, 1,440 Medicare recipients, 1,460 partial pay (self pay), and 3,040 charity care. During the first quarter of the fourth and final year of the project, recruitment of the "newly eligible" population has been slow. These individuals were to replace enrollees found to be ineligible at the time redeterminations of eligibility were done. Enrollment in the project as of January 1984 was 4,313 "newly eligibles" and 5,919 currently eligible Medicaid recipients, or a reduction of 1,687 in the "newly eligible" category.

A Proposal to Relieve Financial Distress at a Congested Urban Medical Center

Project No.: 11-P-97817/9-04
Period: January 1981 - January 1985
Grantee: California Department of Health Services
714-744 P Street
Sacramento, Calif. 95814
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: This 4-year demonstration project tests the cost effectiveness of a county health maintenance system with capitated reimbursement for the medically indigent population served at the Los Angeles County/University of Southern California Medical Center and a community health care center. The approach will demonstrate that:

- Financial viability can be achieved by the use of new "strategies" in the provision of patient care and methods of reimbursement.
- The hospital can serve as an effective case manager, reducing costs and improving health outcomes.

Status: The first 2 years of this project was a developmental phase. The project became operational February 1, 1983. There were 1,451 enrollees in the project as of December 1, 1983, 862 "newly eligibles" and 589 currently eligible Medicaid recipients. The project was expanded to include a second community health center in January 1984.

Other Hospital Payment

Allocation of Resources Under the Budget Constraints Imposed by the British National Health Service

Project No.: 18-P-97647/3-02
Period: March 1980 - September 1983
Funding: \$ 127,794
Grantee: The Brookings Institute
1775 Massachusetts Avenue, N.W.
Washington, D.C. 20036
Project Officer: J. Michael Fitzmaurice
Division of Reimbursement Studies

Description: The Brookings grant examines the way investment decisions are made when the British National Health Service limits expenditures for medical care. It will determine what fraction of the demand for several specific technologies was satisfied and why. The investigators visited Britain to gather epidemiological and expenditure data and information on the decisionmaking process of resource allocation.

Status: In the first year, the investigators added a survey of American and British physicians to the project and increased the planned length of their final report. A full-length book has resulted from this project, entitled "The Painful Prescription: Rationing Hospital Care". It shows how restricting health expenditures in a particular area leads to substitutions of other and possibly less costly medical care treatments. Specifically, the research examines the British methods for rationing choices and drawing inferences about how Americans would respond should they undertake to sharply reduce the growth of medical spending.

PHYSICIAN PAYMENT

Data Development and Analyses

Alternative Methods for Describing Physicians' Services Performed and Billed

Project No.: 500-81-0054
Period: September 1981 - November 1983
Funding: \$ 338,120
Contractor: Health Economics Research, Inc.
824 Boylston Street
Chestnut Hill, Mass. 02167
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This study analyzes the advantages and disadvantages of many different methods of combining or packaging physician services for reporting and billing purposes. This includes analysis of the extent to which current Medicare billing procedures may foster unpackaging. The project has developed and tested new ways of packaging physician services for reimbursement purposes, particularly the feasibility of using medical criteria such as diagnosis and reason-for-visit. National Ambulatory Medical Care data for 1979 and 1980 and Medicare Part B data from Michigan and South Carolina have been used in the project.

Status: A draft final report was received in December 1983. It addressed alternative approaches to packaging and their medical reasonableness, variation in physician charges and inputs across packages, and inefficiencies and inequities introduced by packaging. Types of packages include collapsed procedure packages, office visit packages, special procedure packages, and condition packages. The final report was received in February 1984.

Analysis of Physician Pricing Behavior, Third-Party Administrative Practices

Project No.: 600-76-0058
Period: April 1976 - September 1983
Funding: \$ 741,570
Contractor: Harvard University
School of Public Health
677 Huntington Avenue
Boston, Mass. 02115
Project Officer: William Sobaski
Division of Reimbursement Studies

Description: This study deals with physician response to reimbursement alternatives, including analysis of price trends, relative values, and relations between medicine and private health insurance.

Status: All interim reports were completed. The final report is expected in Spring 1984. The study of price trends showed that wide disparities both within and across areas may be concealed by national price trend figures. A unique methodological approach to relative value studies was undertaken that showed large imbalances exist between payments for technological procedures versus primary care. The nonprofit and for-profit private insurance sectors were shown to employ quite different strategies in establishing relationships with medicine, albeit both cover positive relationships. A new model of supply-and-demand factor interactions in the medical market is being developed.

Aspects of Physician Behavior in Medicare and Medicaid

Project No.: 95-P-97178
Period: September 1978 - December 1983
Funding: \$ 730,313
Grantee: The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This project examines three areas of physician reimbursement:

- Provision of pathology services.
- The effect of reimbursement on physician practice location.
- Simulation and analysis of alternative reimbursement systems.

Status: Work analyzing the effects of reimbursement on physician practice location, the Medicare Economic Index, and Medicare-Medicaid fee levels and differences have been completed. During the fifth year, two ongoing tasks will be completed and eight additional tasks involving simulations and behavioral modeling will be undertaken, using existing data files. The project terminated in December 1983. A final report is expected in Spring 1984.

Alternative Methods for Developing a Relative Value Scale of Physician Fees

Project No.: 500-81-0053
Period: September 1981 - March 1984
Funding: \$ 287,557
Contractor: The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This project explores criteria and methods underlying relative value scales for physician services. Some of these methods will be applied to approximately 100 procedures to develop relative value scales. The study will address the implications of adopting different construction methods.

Status: Five broad classes of approaches to developing relative value scales are discussed in the first year report, received in February 1983. These five classes of methods are charge-based, statistical cost function, time-based, micro costing, and group decisionmaking approaches.

Survey of Physicians' Practice Costs and Incomes: Redesign and Implementation

Project No.: 500-83-0025
Period: June 1983 - June 1985
Funding: \$ 1,508,942
Contractor: National Opinion Research Center
6030 South Ellis
Chicago, Ill. 60637
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This project will assess the design of the survey instruments, the design of the sample, and the data collection methodology of the 1976, 1977, and 1978 Health Care Financing Administration surveys of physicians' practice costs and incomes. A new instrument will be designed, a pretest will be conducted, and then approximately 5,000 physicians will be surveyed in 1984. An important use of the data will be to refine the Medicare Economic Index.

Status: A draft survey questionnaire has been developed. The pretest is scheduled for Spring 1984.

Medical Doctor Diagnosis-Related Groups Algorithms

Project No.: 600-84-0029
Period: February 1984 - October 1984
Funding: \$ 69,890
Contractor: Mandex, Inc.
8302 D Old Courthouse Road
Vienna, Va. 22180
Project Officer: William Sobaski
Division of Reimbursement Studies

Description: The principal purpose of this project is to obtain statistical algorithms that can be used to improve estimates of the values of physician service resources for inpatient care by diagnosis-related groups calculated from the 1981 Health Care Financing Administration (HCFA) statistical files. In addition, suggestions will be made for calculating these values from the 1983 HCFA statistical files and for examining the specialty and locality impact of using national average payment amounts.

Status: The initial planning conference with Office of Research, Office of Legislation and Policy, and Office of Statistics and Data Management staff was held February 8, 1984.

Development of a Physician-Oriented Data Base

Project No.: 500-83-0046
Period: September 1983 - October 1984
Funding: \$ 159,974
Contractor: Mandex, Inc.
8302 D Old Courthouse Road
Vienna, Va. 22180
Project: Benson Dutton
Officer: Division of Reimbursement Studies

Description: This is a pilot study to test the feasibility of developing a physician (practice) oriented Medicare Part B data base. A small sample of the approximately 600,000 uniquely identified practices will be selected. A 1-percent sample of practices would generate, nationally, about 6,000 observations with an average of approximately 300 claims per observation. One part of this effort will identify provider number selection procedures which might produce nonrandom samples. An important aspect of this project will be to estimate any additional costs to the carriers of selecting and writing off practice-specific data.

Status: The contractor has produced a research design listing discrete tasks for constructing the physician-oriented, data-base file. A sample of carriers has been selected and contacted. Record layouts of the Health Care Financing Administration payment record and 5-percent bill summary were obtained. An analysis plan presenting the analytical steps that will be carried out during the course of the project has been prepared. Communication between the carriers and project director continues.

Assignment Rates Revisited

Funding: Intramural
Project: Alma McMillan
Director: Division of Beneficiary Studies

Description: The level of the assignment rate for physicians' services is of continuing interest. Beneficiaries are affected financially when the physician elects not to accept payment for services on an assigned basis. Data on physician assignment rates through 1978 have been published earlier. This study examines recent trends through 1981 in assignment rates by age, sex, race, and State. Assignment rates by physician specialty are also analyzed, as well as the effect of mandatory assignment, i.e., automatic assignment of charges for Medicaid services.

Status: Preliminary data show that in 1981 about 51 percent of the \$14.8 billion in physicians' charges to aged Medicare beneficiaries was assigned; about 69 percent of the \$1.9 billion in charges to disabled beneficiaries was assigned. These figures represent an increase from the rate of 47 percent for the aged in 1975 and an increase from the rate of 64 percent for the disabled in 1976. The exclusion of charges for Medicaid services, which are automatically assigned, reduces the assignment rate several percentage points for both aged and disabled beneficiaries. For aged enrollees, the rate dropped 6 percentage points to 45 percent; for disabled enrollees the rate dropped 8 percentage points to 61 percent. A working paper on this subject is being prepared.

Prospective Payment of Physicians

Funding: Intramural
Project James Cantwell
Director: Division of Reimbursement Studies

Description: Section 603 of Public Law 98-21, the Social Security Amendments of 1983, requires the Secretary, Department of Health and Human Services, during Fiscal Year 1984, to begin the collection of data necessary to compute, by diagnosis-related groups (DRG's), the amount of physician charges for services furnished to hospital inpatients classified in those DRG's. A report to Congress due in 1985 must include recommendations on the advisability and feasibility of determining payment for inpatient physicians' services on a DRG-type classification.

Status: Intramural work has begun to examine the level and stability of outlays for physician services by DRG's in Medicare claims data samples. This initial work will emphasize regional, specialty, and type of service patterns for high frequency DRG's. As larger data sets become available, analyses will expand to the remaining DRG's. Data file construction and specification of data display tables to be produced began in June 1983. A grant to study DRG-based physician reimbursement schemes was awarded to the Center for Health Economics Research in September 1983.

Other Physician Payment

Physician Reimbursement and Continuing Care under Medicaid in Suffolk County, New York

Project No.: 11-P-98052/2-02
Period: September 1981 - December 1986
Funding: \$ 672,222
Grantee: New York Department of Social Services
Division of Medical Assistance
40 North Pearl Street
Albany, N.Y. 12243
Project Sherrie Fried
Officer: Division of Health Systems and Special Studies

Description: This demonstration is designed to test the impact of alternative methods of physician reimbursement on the provision of continuing care for Medicaid children in Suffolk County, N. Y. The methods include the current fee schedule, a fee-for-service/continuing care method that reimburses physicians at a higher rate for accepting continuing comprehensive care, and a comprehensive prepayment plan.

Status: The project began the operational phase in July 1983. Major milestones include approval by the Health Care Financing Administration of the continuation request; development of capitation rates and an augmented fee schedule; development of claim payment, data collection, and management reporting systems; and enrollment of physicians and recipients. As of January 1984, 2,465 children and 82 physicians were enrolled in the demonstration. A 12-month no cost extension was approved to extend the demonstration until December 1986.

Studies in Physician Reimbursement

Project No.: 95-P-97309/2
Period: June 1979 - December 1982
Funding: \$ 330,802
Grantee: Princeton University
Department of Economics
Princeton, N.J. 08540
Project: James Cantwell
Officer: Division of Reimbursement Studies

Description: This study examined the role of fee schedules in physician reimbursement under third-party payment systems in Europe and Canada. Specific tasks included development of the conceptual basis for fee schedules and analytic frameworks for assessment of changes within them, as well as descriptive analyses of fee schedules and relative price structures in the United States.

Status: Several country-specific papers have been produced on physician fee determination systems. The paper on the French system was written by Simone Sandier of CREDOC, the French health economics research institute. The paper on the German physician fee system was written by the late Ulrich Geissler, and an excerpt from that paper will be published in the Spring 1984 issue of the Health Care Financing Review. Uwe Reinhardt's paper on the German health funds and negotiations under their system was published in the December 1981 issue of the Health Care Financing Review. Both the German and French systems have shown that uniform relative value schedules are possible; in fact, the French in effect have a nationwide fee schedule. The Germans have been trying to alter their relative value schedules to improve the relative position of primary care services, but as yet without much success. A revised draft final report is expected in Summer 1984. It will address theoretical perspectives on physician compensation in the United States, Canada, France, West Germany, and Italy, and will be available in English and French.

Impact of Physician Supply and Regulation on Physician Fees and Utilization of Services

Project No.: 18-P-97619/5
Period: March 1980 - March 1983
Funding: \$ 408,287
Grantee: Blue Cross/Blue Shield of Michigan
20800 Greenfield
Oak Park, Mich. 48237
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: Blue Cross and Blue Shield of Michigan (BCBSM) has used paid claims files to examine the issue of physician-induced demand. BCBSM has also examined market areas in Michigan with private and Medicare paid claims from 1975 to 1980. In addition, the study is investigating the impact of physician supply and regulation on the price and quantity of physician services. To supplement the paid claims data, BCBSM has surveyed a sample of Michigan physicians to determine amenities, workload/hours, non-Blue Shield volume and charges. This project will describe and analyze variation in per capita use across market areas. BCBSM is using patient illness diagnostic tracers from physician billing data. The inducement hypothesis is to be tested using a "Reinhardt test" of physicians' fees while holding relevant supply, demand, and amenities variables constant.

Status: The study identified 15 market areas in Michigan and showed that there were major differences between market areas in use rates as well as the growth in those rates. The areas with the highest use rates in 1975 were also the markets with the highest growth in use. On induced demand, the data support the hypothesis that an increase in the availability of doctors increases the use of services, but the evidence refutes the target income hypothesis by showing that fees move toward competitive levels. BCBSM interim reports were very useful in resolving the clinic locality issue in Michigan raised by Congressman Robert Davis (R-MI) in 1982. Other reports received include:

- "Medicare Assignment Rates in Michigan."
- "The Effects of Physician Availability on Fees and the Demand for Doctors' Services."
- "Survey of Michigan Physicians' Practice Characteristics."
- "Medicare Fees, Use, and Assignment Rates in Michigan's Physician Service Markets."
- "Fees or Use? What's Responsible for Rising Health Care Costs?"
- "The Determination of Medicare Market Areas and Medicare Fees, and Use in Michigan."

A final report is due in April 1984.

Creating Diagnosis-Related-Group-Based Physician Reimbursement Schemes: A Conceptual and Empirical Analysis

Project No.: 18-P-98387
Period: September 1983 - June 1985
Funding: \$ 503,424
Grantee: Center for Health Economics Research
824 Boylston Street
Chestnut Hill, Mass. 02167
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: Under this project, conceptual analyses will explore alternative diagnosis-related-group-based physician payment schemes, using alternative packaging methods developed under an earlier Health Care Financing Administration contract. Empirical analyses will be conducted using Medicare Part A and Part B data for New Jersey, North Carolina, and Michigan, and Medicaid data from New Jersey.

Status: Data-release agreements with carriers and intermediaries have been signed, and analysis of some of the data has begun.

LONG-TERM CARE

Skilled Nursing Facility Prospective Payment

Alternative Nursing Home Reimbursement Systems for Medicare

Project No.: 18-P-98274/3-01
Period: January 1983 - June 1984
Funding: \$ 230,601
Grantee: The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037
Project Officer: Philip Cotterill
Division of Economic Analysis

Description: This study will simulate alternative approaches to prospective payment for Medicare skilled nursing facilities (SNF's) and investigate administrative factors that affect the efficiency of patient-related rate payment systems. The study utilized Medicare SNF cost reports and Medicaid cost reports for 3,500 nursing homes in 10 States for the period 1978-80. The 10 States included in the study were: California, Connecticut, Georgia, Illinois, Maryland, Massachusetts, Minnesota, New York, Washington, and West Virginia.

Status: Analysis of the Medicare cost reports of skilled nursing facilities (SNF's) has shown that several proxy measures of case mix are important factors in explaining differences in SNF per diem costs. Higher costs are associated with a greater percentage of Medicare days, a higher number of admissions per bed, and greater nursing hours per inpatient day. These factors may indicate facilities with a greater orientation towards the short-term, rehabilitative Medicare patient. They only partially explain the higher costs observed for hospital-based, as opposed to freestanding, SNF's.

New York State Capitation Payment System for Long-Term Care

Project No.: 11-P-98194/2-02
Period: March 1982 - June 1986
Funding: \$ 659,632
Grantee: New York State Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Description: The purpose of this demonstration is to reduce the backup of hospitalized Medicaid patients who cannot be discharged because of the limited availability of nursing home beds. In an effort to control the escalation of hospital expenditures, the Rochester Area Hospitals' Corporation has proposed a risk-sharing capitation method of reimbursement which provides positive incentives for appropriate placement.

Status: The project is still in the developmental stage. This period has been characterized by intensive negotiations between the New York State Department of Social Services and the Rochester Area Hospitals' Corporation. Discussion has focused on the demonstration's design and methodology. The issue that has delayed the implementation of the project has been the determination of the year to be used as the basis for the hospital per diem. Recent fluctuations in the number of alternate level of care days have made it difficult to establish base-year data.

West Virginia Long-Term Care, Quality-Cost Control System

Project No.: 11-P-97149/4-03
Period: April 1980 - December 1983
Grantee: State of West Virginia
Department of Welfare
1200 Washington Street
Charleston, W. Va. 25305
Project Officer: Tom Kickham
Division of Long-Term Care Experimentation

Description: This project is designed to implement and evaluate a Medicaid long-term care prospective reimbursement system based on reimbursement for services needed by and provided to patients at a reasonable cost. The reimbursement system utilizes three components on which to set the facility rate: nursing services, operating costs, and capital investment.

Status: The demonstration ended December 31, 1983. Section 961 of the Omnibus Reconciliation Act of 1980 (Public Law 96-499) repealed the requirement that SNF's and ICF's under Medicaid be reimbursed on a reasonable cost basis. This allowed West Virginia to request an amendment to their Medicaid State Plan to allow the methodology to be used for the investment component of their reimbursement system. HCFA approved the plan amendment effective January 1, 1984.

Longitudinal Study of the Impact of Prospective Reimbursement Under Medicaid on Nursing Home Care in Maine

Project No.: 18-P-98307/1-01
Period: June 1983 - June 1986
Funding: \$ 467,314
Grantee: University of Southern Maine
Human Services Development Institute
246 Deering Avenue
Portland, Maine 04102
Project Officer: Philip Cotterill
Division of Economic Analysis

Description: This project studies the recently implemented nursing home prospective reimbursement system in Maine. The study will provide a longitudinal evaluation of the design and implementation of the system for intermediate care facilities in the State and of the system's effectiveness in achieving the policy goals of containing costs, maintaining or improving quality, and ensuring access to nursing home care by Medicaid recipients. The study consists of three major components:

- An impact analysis of the effects of prospective reimbursement on costs, quality, and access.
- A case study of the politics of the implementation of prospective reimbursement.
- An analysis of organizational and management response of nursing home administrators to the changes resulting from prospective reimbursement.

The hypotheses of the study are closely tied to the objectives of recently passed reimbursement legislation which includes incentives for maintaining and increasing Medicaid patient load. The grantee will also try to measure immediate versus long-term effects of the new system on costs to the State.

Status: Work to date has focused on determining how case mix will be measured in the study. Tentative plans are to compare three measures: two sets of patient groups and State level-of-care information.

New York State Case-Mix Prospective Reimbursement System for Long-Term Care

Project No.: 11-P-98325/2-01
Period: August 1983 - August 1986
Funding: \$ 416,012
Grantee: New York State Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: Elizabeth S. Cornelius
Division of Long-Term Care Experimentation

Description: The New York State Department of Social Services was awarded a section 1115 grant, effective August 7, 1983, to develop, test, and refine a long-term care prospective reimbursement system based upon clusters of patient characteristics. This is a 3-year grant being conducted by the New York State Department of Health and Rensselaer Polytechnic Institute. The system will build upon the results of research conducted at Yale University which developed clusters of patients in relation to staff resources used (Resource Utilization Groups). The purpose of the project is to promote efficiency by associating payment levels with patient characteristics which indicate the amount of actual services needed by patients.

Status: This project is still in the developmental stage. The State has hired the project staff and has selected a national and a State advisory group. These groups have met and have developed a timetable for the project.

Channeling

Evaluation of Coordinated Community-Oriented Long-Term Care Demonstration

Project No.: 500-80-0073
Period: September 1980 - December 1983
Funding: \$ 2,373,876
Contractor: Berkeley Planning Associates
3200 Adeline Street
Berkeley, Calif. 94703
Project Officer: Spike Duzor
Evaluative Studies Staff

Description: This long-term care project evaluates a series of demonstration projects on the delivery of coordinated community care services. The demonstrations test whether care tailored to clients' needs can keep them in the community instead of moving them into expensive institutional care settings.

Status: The contractor has completed draft case studies for the participating projects. These case studies highlight the history and origin of the project, describe project organization, and operation issues. A final report is expected in September 1984 and will focus on quality of care and cost-effectiveness issues.

National Long-Term Care Channeling Demonstrations

Period: September 1980 - May 1985

Description: This is a major national research and demonstration program. It is a combined effort of three components in the Department of Health and Human Services: the Health Care Financing Administration (HCFA); the Office of the Assistant Secretary for Planning and Evaluation, Office of the Secretary; and the Administration on Aging, Office of Human Development Services. The program is testing whether and to what extent the long-term care needs of elderly impaired persons can be met in a cost-effective way through a community-based system of comprehensive needs assessment, care planning, and case management. These components are the core channeling services. Five of the projects were designated as "complex model projects." These projects alter the basic channeling model by adding three program elements under HCFA waivers: expanded Medicare and Medicaid service coverage, authorization to approve reimbursement for services, and limitations on per capita expenditures.

Project Nos.: 11-P-98211/4-02
HHS-100-80-0136
Funding: \$ 932,896
Contractor/ Florida Department of Health and Rehabilitative Services
Grantee: 1317 Winewood Boulevard
Tallahassee, Fla. 32301
Project William Saunders
Officer: Division of Long-Term Care Experimentation

Status: The Miami Jewish Home and Hospital for the Aged has been designated as the organization responsible for implementing the Florida project. This site has been selected as a complex model project. The project catchment area includes the city of Miami and several surrounding communities. The project began serving clients in May 1982, and is serving a caseload of 450 clients.

Project No.: HHS-100-80-0138
Funding: \$ 700,000
Contractor: Kentucky Cabinet for Human Resources
275 East Main Street
Frankfort, Ky. 40621
Project William Saunders
Officer: Division of Long-Term Care Experimentation

Status: The Kentucky Department for Social Services has been designated as the agency responsible for implementing the Kentucky project. This site has been selected as a basic model project. The project catchment area covers eight rural counties in eastern Kentucky. The project began serving clients in February 1982, and is serving a caseload of 250 clients.

Project No.: HHS-100-80-0139
Funding: \$ 609,839
Contractor: Maine Department of Human Services
State House, Station II
Augusta, Maine 04333
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Status: The Maine demonstration site is a basic model project administered under a subcontract with Southern Maine Senior Citizens, Inc., an Area Agency on Aging in Portland. The 2-county catchment area, Cumberland and York Counties, covers 2,000 square miles. The project began serving clients in February 1982, and reached an active caseload of 216 clients by the end of July 1983.

Project Nos.: 11-P-98210/1-02
HHS-100-80-0141
Funding: \$ 1,657,617
Contractor/Grantee: Massachusetts Department of Public Welfare
600 Washington Street
Boston, Mass. 02111
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Status: The Massachusetts channeling demonstration is a complex model site operated by Greater Lynn Senior Services. The catchment area includes Greater Lynn and the Beverly area. The project began serving clients in May 1982. The project reached its target caseload of 300 clients by the end of July 1983. The project's major referral sources are the Visiting Nurse Association, hospitals, and the Greater Lynn Senior Services.

Project No.: 11-P-98213/2-02
Grantee: New York State Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: Thomas M. Kickham
Division of Long-Term Care Experimentation

Status: The Rennselaer County Department for the Aging has been designated as the agency responsible for implementing the New York project. This site has been selected as a complex model project. The project catchment area is Rennselaer County, New York. The project began serving clients in May 1982 and currently is serving a caseload of 200 clients.

Project No.: 11-P-98209/5-02
Grantee: Ohio Department of Public Welfare
30 East Broad Street
Columbus, Ohio 43215
Project Officer: Thomas M. Kickham
Division of Long-Term Care Experimentation

Status: The Cuyahoga County Board of Commissioners has been designated as the agency responsible for implementing the Ohio project. The project site is administered by the Western Reserve Area Agency on Aging. The project catchment area covers Cuyahoga County, which consists of the city of Cleveland and surrounding suburbs. The project began serving clients in May 1982, and is serving a caseload of 415 clients.

Project Nos.: 11-P-98212/3-02
HHS-100-80-0146
Funding: \$ 2,235,982
Contractor/Grantee: Pennsylvania Department of Public Welfare
Health and Welfare Building
Harrisburg, Pa. 17120
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Status: The Pennsylvania channeling project is operated through a subcontract with the Philadelphia Corporation for Aging. This site is a fully centralized complex model project site. The catchment area covers more than 129 square miles and includes the city and county of Philadelphia. The project began serving clients in May 1982. By the middle of June 1983, the project reached its target caseload of 500 clients. For the duration of the project's maintenance phase, it expects to continue serving an active caseload of 500-520 clients.

Home Health

Home Health Agency Prospective Payment Demonstration

Project No.: 500-84-0021
Period: December 1983 - December 1988
Funding: \$ 1,556,975
Contractor: Abt Associates, Inc.
1055 Thomas Jefferson Street, N.W.
Washington, D.C. 44577
Project Officer: William Saunders
Division of Long-Term Care Experimentation

Description: The purpose of this project is to develop and test alternative methods of paying home health agencies on a prospective basis for services furnished under the Medicare and Medicaid programs. The demonstration will enable the Health Care Financing Administration to evaluate the effects of various methods of prospective payment on Medicare and Medicaid expenditures, quality of home health care, and home health agency operations.

Status: A contract was awarded in December 1983 to Abt Associates for development and implementation of the demonstration. The initial phase of the project will involve the development of the specific payment methodologies; establishment of a research design and evaluation strategy; design of a process to monitor the quality of care provided under the demonstration; development of data collection and status reporting plans; and identification, selection, and training of participating home health agencies. The payment methodologies will then be tested for 3 years to determine the effects on Medicare and Medicaid expenditures, quality of care, and home health agency operations.

Assess (State) Tax Incentives as a Means of Strengthening the Informal Support System for the Elderly

Project No.: 18-C-98410/9-01
Period: September 1984 - September 1986
Funding: \$ 167,168
Grantee: Center for Health and Social Services Research
155 South El Molino
Pasadena, Calif. 91101
Project Officer: Sherry A. Terrell
Division of Beneficiary Studies

Description: The purpose of this project is to study selected State (Arizona, Idaho, Iowa, and Oregon) tax incentives that are believed to stimulate the informal caregiver system and reduce either current or anticipated demands on the formal long-term care system. Specific objectives are:

- To describe and analyze tax incentives that have been implemented in selected States.
- To develop a predictive model to identify those persons in the general elderly population and their informal caregivers who are likely to take advantage of tax incentives.
- To determine the potential impact of the tax incentive programs in preventing or delaying institutionalization.
- To synthesize and disseminate findings.

Status: The project is in the developmental phase. The first 3 months were dedicated to finalizing the research design, gathering background information, identifying appropriate study States, recruiting study participation, and identifying data sources.

Community-Based Care

Medicare/Medicaid Hospice Demonstration

Period: October 1980 - March 1985

Description: This demonstration was designed to gather data on the cost, utilization, and quality of hospice care with major emphasis on the provision of home care services (for example, continuous nursing care and prescription drugs). There are 26 sites, and each site provides care to terminally ill Medicare beneficiaries and Medicaid recipients having a life expectancy of 6 months or less. An interdisciplinary team approach is utilized to maintain the patient at home in a comfortable, alert, and pain-free state.

Status: Because Public Law 97-248 mandated a Medicare hospice benefit and the extension of the demonstration, each site continues to enroll Medicare beneficiaries. The Medicaid portion of the project ended September 30, 1983. The number of Medicaid participants was unexpectedly small, approximately 363 persons. In contrast, Medicare enrollments have been substantial throughout the demonstration, totaling an estimated 12,689 beneficiaries by January 31, 1984. The Medicare portion of the demonstration is being systematically phased out as the project sites become Medicare certified hospice providers. The final evaluation report by the independent evaluator, Brown University, should be available by Summer 1984.

Project No.: 95-P-50109/9-02
Grantee: Santa Barbara Visiting Nurse Association
401 North Milpas Street
Santa Barbara, Calif. 93101
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50022/9-02
Grantee: San Diego Hospice Corporation
3243 Mission Village Drive
San Diego, Calif. 92123
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50194/9-02
Grantee: Hospice of Marin
77 Mark Drive, #16
San Rafael, Calif. 94903
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50148/9-02
Grantee: Pacifica Home Care
 1386-B West Seventh Street
 San Pedro, Calif. 90732
Project Officer: Teresa Schoen
 Division of Long-Term Care Experimentation

Project No.: 95-P-50149/9-02
Grantee: Hospital Home Health Care Agency of California
 23228 Hawthorne Boulevard
 Torrance, Calif. 90505
Project Officer: Teresa Schoen
 Division of Long-Term Care Experimentation

Project No.: 95-P-50020/8-02
Grantee: Boulder County Hospice, Inc.
 2825 Marine Street
 Boulder, Colo. 80303
Project Officer: Dennis M. Nugent
 Division of Long-Term Care Experimentation

Project No.: 95-P-50037/1-02
Grantee: The Connecticut Hospice, Inc.
 61 Burban Drive
 Branford, Conn. 06405
Project Officer: Teresa Schoen
 Division of Long-Term Care Experimentation

Project No.: 95-P-50120/4-02
Grantee: Hospice, Inc.
 111 N.W. 10th Avenue
 Miami, Fla. 33128
Project Officer: Teresa Schoen
 Division of Long-Term Care Experimentation

Project No.: 95-P-50079/4-02
Grantee: Hospice Care, Inc.
 3400 70th Avenue North
 Pinellas Park, Fla. 33565
Project Officer: Teresa Schoen
 Division of Long-Term Care Experimentation

Project No.: 95-P-50083/1-02
Grantee: Hospice of the Good Shepherd, Inc.
 P.O. Box 144
 Waban, Mass. 02168
Project Officer: Teresa Schoen
 Division of Long-Term Care Experimentation

Project No.: 95-P-50085/1-02
Grantee: University of Massachusetts Medical Center
 Palliative Care Service, Inc.
 55 Lake Avenue North
 Worcester, Mass. 01605
Project Officer: Teresa Schoen
 Division of Long-Term Care Experimentation

Project No.: 95-P-50154/5-02
Grantee: Bethesda Lutheran Medical Center
 559 Capitol Boulevard
 St. Paul, Minn. 55103
Project Officer: Dennis M. Nugent
 Division of Long-Term Care Experimentation

Project No.: 95-P-50122/7-02
Grantee: Lutheran Medical Center
 2639 Miami Street
 St. Louis, Mo. 63118
Project Officer: Dennis M. Nugent
 Division of Long-Term Care Experimentation

Project No.: 95-P-50001/2-02
Grantee: Overlook Hospital
 193 Morris Avenue
 Summit, N.J. 07901
Project Officer: Teresa Schoen
 Division of Long-Term Care Experimentation

Project No.: 95-P-50135/6-02
Grantee: Hospital Home Health Care, Inc.
 500 Walter N.E., Suite 310
 Albuquerque, N.Mex. 87102
Project Officer: Dennis M. Nugent
 Division of Long-Term Care Experimentation

Project No.: 95-P-50006/2-02
Grantee: Cabrini Hospice
 227 East 19th Street
 New York, N.Y. 10003
Project Officer: Teresa Schoen
 Division of Long-Term Care Experimentation

Project No.: 95-P-50111/2-02
Grantee: Genesee Region Home Care Association
 311 Alexander Street
 Rochester, N.Y. 14604
Project Officer: Teresa Schoen
 Division of Long-Term Care Experimentation

Project No.: 95-P-50267/0-02
Grantee: Providence Medical Center
 N.E. 49th and Glisan
 Portland, Oreg. 97213
Project Officer: Teresa Schoen
 Division of Long-Term Care Experimentation

Project No.: 95-50068/6-02
Grantee: Visiting Nurse Association of Dallas
 8200 Brookriver Drive, Suite 200N
 Dallas, Tex. 75247
Project Officer: Dennis M. Nugent
 Division of Long-Term Care Experimentation

Project No.: 95-P-50147/6-02
Grantee: St. Benedict Hospital and Nursing Home
 323 E. Johnson
 San Antonio, Tex. 78204
Project Officer: Dennis M. Nugent
 Division of Long-Term Care Experimentation

Project No.: 95-P-50040/1-02
Grantee: Northern Vermont Respond
 Visiting Nurse Association, Inc.
 260 College Street
 Burlington, Vt. 05401
Project Officer: Teresa Schoen
 Division of Long-Term Care Experimentation

Project No.: 95-P-50043/3-02
Grantee: Hospice of Northern Virginia
 4715 North 15th Street
 Arlington, Va. 22205
Project Officer: Teresa Schoen
 Division of Long-Term Care Experimentation

Project No.: 95-P-50182/3-02
Grantee: Medical College of Virginia
 Box 37, MCV Station
 Richmond, Va. 23298
Project Officer: Teresa Schoen
 Division of Long-Term Care Experimentation

Project No.: 95-P-50104/0-02
Grantee: Community Home Health Care
 200 West Thomas Street
 Seattle, Wash. 98119
Project Officer: Teresa Schoen
 Division of Long-Term Care Experimentation

Project No.: 95-P-50121/5-02
Grantee: Bellin Memorial Hospital
744 South Webster Avenue
Green Bay, Wis. 54305
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50132/5-02
Grantee: Rogers Memorial Hospital, Inc.
34810 Pabst Road
Oconomowoc, Wis. 53066
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Hospice Demonstration--State Medicaid Component

Period: October 1980 - September 1983

Description: Fourteen States were granted waivers to participate in this project, which is designed to gather data on the cost, utilization, and quality of hospice care provided to Medicare and Medicaid patients having a life expectancy of 6 months or less. Under the auspices of the States, an array of home care services (including continuous nursing care, bereavement assessment and counseling, and respite care) was provided at several sites. Inpatient hospice care was also available at some sites.

Status: Active enrollment of Medicaid patients ceased on October 1, 1982, and the Medicaid portion of the project entered a wind-down phase. State Medicaid participation in the project ended on September 30, 1983. The Medicaid patient enrollment was unexpectedly small, totaling approximately 363 persons versus 12,689 Medicare beneficiaries.

Project No.: 11-P-50233/9-02
Grantee: Department of Health Services
714 P Street, Room 1253
Sacramento, Calif. 95814
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 11-P-50237/8-02
Grantee: Colorado Department of Social Services
1575 Sherman Street
Denver, Colo. 80203
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 11-P-50255/1-02
Grantee: Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Conn. 06115
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 11-P-50241/4-02
Grantee: Department of Health and Rehabilitative Services
Building 6, Room 233
1317 Winewood Boulevard
Tallahassee, Fla. 32301
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 11-P-50260/1-02
Grantee: Department of Public Welfare
600 Washington Street
Boston, Mass. 02111
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 11-P-50226/5-02
Grantee: Department of Public Welfare
Space Center Building, First Floor
444 Lafayette Road
St. Paul, Minn. 55164
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 11-P-50242/2-02
Grantee: New Jersey Department of Human Services
324 East State Street
Trenton, N.J. 08625
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 11-P-50270/6-02
Grantee: New Mexico Human Services Department
P.O. Box 2348
Santa Fe, N. Mex. 87503
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 11-P-50256/2-02
Grantee: New York State Department of Social Services
Ten Eyck Building
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 11-P-50208/6-02
Grantee: Texas Department of Human Resources
Banister Lane Building
P.O. Box 2960
Austin, Tex. 78769
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 11-P-50231/1-02
Grantee: Agency of Human Services
103 South Main Street
Waterbury, Vt. 05676
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 11-P-50238/3-02
Grantee: Virginia Department of Health
109 Governor Street
Richmond, Va. 23219
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 11-P-50229/0-02
Grantee: Department of Social and Health Services
Division of Medical Assistance, LK-11
Olympia, Wash. 98504
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 11-P-50264/5-02
Grantee: Department of Health and Social Services
Room 643
1 West Wilson Street
Madison, Wis. 57301
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

National Hospice Study

Project No.: 99-P-97793/1-03
Period: September 1980 - September 1983
Funding: \$ 2,890,840
Grantee: Brown University
Division of Biology and Medicine
Box G
Providence, R.I. 02912
Project Officer: Spike Duzor
Evaluative Studies Staff

Description: This study will evaluate the effects of providing hospice services to terminally ill Medicare and Medicaid patients. It will determine whether hospice care can provide the necessary emotional, psychological, and medical support to the terminally ill which would permit them to remain at home during their final months of illness and eliminate long and costly periods of institutionalization.

Status: Analytical files are being constructed for the final analysis. These files will link individual patient service utilization and cost information with detailed patient health status profiles and interviews. The final report is expected in Summer 1984.

Deinstitutionalization of the Chronically Mentally Ill

Project Officer: Jean L. Bainter
Division of Long-Term Care Experimentation

Description: This project is a joint effort between the Departments of Housing and Urban Development (HUD) and Health and Human Services under the Demonstration for Deinstitutionalization of the Chronically Mentally Ill. HUD is providing loans for the construction of community-based housing under Section 202, and rental assistance under Section 8. The Health Care Financing Administration is providing Medicaid waivers to permit reimbursement for a 3-year period for services such as case management, life skills training, supervision, and transportation.

Status: To date, 12 States have submitted Section 1115 waiver-only applications and received approval. There are now 42 sites in operation serving approximately 415 residents. Additional sites are in operation in States not seeking waivers. Several levels of evaluation have been carried out resulting in Section 202 standards and criteria for small, scattered site housing. The standards include service requirements for this population that must be monitored by the State Mental Health Authority. To date, there are no findings relating to the cost-effectiveness of the demonstration.

A Model Addressing the Residential Needs of the Chronically Mentally Ill

Project No.: 11-P-98117/6-02
Period: July 1982 - July 1985
Grantee: Arkansas Department of Human Services
Seventh and Main Streets
Little Rock, Ark. 72201

Effective and Efficient Community Support Services for the Chronically Mentally Ill

Project No.: 11-P-98000/3-03
Period: September 1981 - September 1984
Grantee: Office of Health Care Financing
1331 H Street N.W., Fifth Floor
Washington, D.C. 20005

Cost-Effective Community Alternatives to Institutionalization of the Chronically Mentally Ill

Project No.: 11-P-97575/4-03
Period: April 1981 - March 1984
Grantee: Georgia Department of Medical Assistance
2 Martin Luther King Drive
Atlanta, Ga. 30334

Cost-Effective Comprehensive Community Residential Treatment of the Chronically Mentally Ill

Project No.: 11-P-98242/1-02
Period: November 1982 - November 1985
Grantee: Maine Department of Human Services
Statehouse, Region II
Augusta, Maine 04333

Housing and Urban Development Demonstration Program for the Chronically Mentally Ill

Project No.: 11-P-97563/5-04
Period: May 1980 - April 1985
Grantee: Minnesota Department of Public Welfare
658 Cedar Street
St. Paul, Minn. 55155

Cost-Effective Community Alternatives to Deinstitutionalization of the Chronically Mentally Ill

Project No.: 11-P-98100/1-02
Period: November 1982 - November 1985
Grantee: New Hampshire Division of Welfare
Hazen Drive
Concord, N.H. 03301

Services in HUD Transitional Housing for Chronically Mentally Ill

Project No.: 11-P-97799/2-02
Period: August 1982 - July 1985
Grantee: New Jersey Department of Human Services
Division of Medical Assistance
324 East State Street
Trenton, N.J. 08625

Deinstitutionalization of the Chronically Mentally Disabled, Cost-Effective Community Alternatives

Project No.: 11-P-98118/1-02
Period: June 1982 - June 1985
Grantee: Department of Social and Rehabilitative Services
600 New London Avenue
Cranston, R.I. 02920

Housing and Urban Development Demonstration Program for the Chronically Mentally Ill

Project No.: 11-P-97952/4-03
Period: May 1981 - May 1985
Grantee: Tennessee Department of Public Health
Bureau of Medicaid Administration and Coordination
283 Plus Park Boulevard
Nashville, Tenn. 37217

Community Alternatives to the Institutionalization of the Chronically Mentally Ill

Project No.: 11-P-98259/1-01
Period: March 1983 - March 1986
Grantee: Connecticut Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Conn. 06115

Cost-Effective Community Residential Treatment for the Mentally Ill

Project No.: 11-P-97787/1-03
Period: August 1981 - July 1984
Grantee: Vermont Agency of Human Services
Department of Social Welfare
103 South Main Street
Waterbury, Vt. 05676

Highline Independent Apartment Living Project

Project No.: 11-P-98200/0-02
Period: April 1982 - April 1985
Grantee: Department of Social and Health Services
Division of Medical Assistance, LK-11
Olympia, Wash. 98504

On Lok Community Care Organization for Dependent Adults

Project No.: 95-P-97239/9-04
Period: February 1979 - October 1983
Grantee: On Lok Senior Health Services
1441 Powell Street
San Francisco, Calif. 94133
Project Officer: Jean L. Bainter
Division of Long-Term Care Experimentation

Description: This is a community-based demonstration providing long-term health and health-related services in a health maintenance organization mode. Services are provided to those functionally disabled elderly in the Chinatown-North Beach area of San Francisco that meet the State's eligibility criteria for 24-hour institutional care and who are entitled to Medicare. Medicare waivers were granted to provide reimbursement for a comprehensive package of services and to build a data base for the development of a capitation system of reimbursement.

Status: The On Lok Community Care Organization for Dependent Adults demonstration was extended through October 31, 1983, to provide sufficient time to initiate a 3-year, at-risk, capitated payment demonstration (Medicare and Medicaid) that was mandated by Congress in the Social Security Amendments of 1983. This demonstration is being evaluated by the Health Care Financing Administration in its cross-cutting, long-term care study. On Lok's final report is in preparation and includes findings from a comparison study and analyses of cost and services data on the total population.

Study of the Virginia Pre-Admission Screening Program

Project No.: 18-P-98080/3-01
Period: August 1981 - March 1983
Funding: \$ 99,880
Grantee: Virginia Center on Aging
Virginia Commonwealth University
Richmond, Va. 23284
Project Officer: Marni Hall
Division of Economic Analysis

Description: This is a followup study of Virginia's pre-admission screening program for nursing home placement. Research will compare the family supports available and costs of care for two groups of nursing home residents and two groups of community residents using long-term care services.

Status: Preliminary findings indicate that during the 18-month period of the study:

- No detrimental effects, such as an increase in mortality or decline in functional status, were found to occur that could not be explained by initial differences among the groups.
- The screened denial group continues to cost the Medicaid program less than the approval group despite increasing rates of institutionalization. Moreover, they appear to experience no deleterious effects that would indicate needed services were denied.

The final report is expected in Spring 1984.

Social Health Maintenance Organization Project for Long-Term Care

Project No.: 18-P-97604/1-04
Period: March 1980 - May 1986
Funding: \$ 1,553,478
Grantee: Brandeis University
University Health Policy Consortium
415 South Street
Waltham, Mass. 02254
Project Officers: Tom Kickham and Sidney Trieger
Division of Long-Term Care Experimentation

Description: The purpose of this project is to develop and implement the concept of a social health maintenance organization (S/HMO) for long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services would be provided by or through the S/HMO at a fixed annual prepaid capitation sum.

Status: Four S/HMO demonstration sites have been selected by the University Health Policy Consortium (UHPC). These sites include two HMO types that will be adding long-term care services to their service packages, and two long-term care providers that will be adding acute care services to their service packages. UHPC has been successful in assisting the sites in obtaining private foundation funding to finance the development period. UHPC and the sites have developed a common service package, financing plans, and risk-sharing arrangements. The sites have submitted final protocols with specific details and application for Medicare and Medicaid waivers. The sites are expected to become operational in Spring 1984.

Multipurpose Senior Services Project

Project No.: 11-P-97553/9-04
Period: October 1979 - March 1984
Grantee: State of California Health and Welfare Agency
1600 Ninth Street
Room 460
Sacramento, Calif. 95814
Project Officer: Michael J. Baier
Division of Long-Term Care Experimentation

Description: The purpose of this project is to reduce client hospital and skilled nursing facility days, to reduce total expenditures by social and health services for clients, and to improve clients' functional abilities. Service delivery is administered through eight separate demonstration sites located throughout the State. Each site has an average of 60 organizations with which they contract for the provision of direct services to clients. A wide range of waived health and social services are provided under the project.

Status: The project is in its fourth and final year. Service delivery under the demonstration ended June 30, 1983, for the 1,900 experimental clients (a comparison group of 2,500 clients was also maintained by the project). The grantee secured approval of a Section 2176 home and community-based waiver program beginning July 1, 1983. A 6-month extension of the project was granted to allow the grantee sufficient time to complete its data analysis/evaluation activities. A final report for the demonstration is expected in April 1984.

Demonstration of Community-Wide Alternative Long-Term Care Model

Project No.: 11-P-90130/2-09
Period: July 1976 - July 1986
Funding: \$ 960,938
Grantee: New York State Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: William Saunders
Division of Long-Term Care Experimentation

Description: The New York State Department of Social Services is demonstrating alternative approaches to delivering and financing long-term care to the adult disabled and elderly Medicaid population of Monroe County, New York. The project has developed the Assessment for Community Care Services (ACCESS) model as a centralized unit responsible for all aspects of long-term care for Monroe County residents 18 years of age or over who are eligible for Medicaid and have long-term health care needs. ACCESS staff provide each client with comprehensive needs-assessment and case-management services.

Status: The project received waivers to permit provision of certain community long-term care services not normally provided under Medicaid in New York. Since the project became operational in 1977, more than 19,000 people with potential long-term care needs have received assessments under this program. The demonstration has been extended until 1986. The extension will allow time to study effects on the health care system in Monroe County.

Continued Demonstration of a Long-Term Care Center Through Inclusion and Expansion of Title XVIII

Project No.: 95-P-97254/2-04
Period: August 1980 - July 1986
Funding: \$ 2,308,619
Grantee: Monroe County Long-Term Care Program, Inc.
55 Troup Street
Rochester, N.Y. 14608
Project Officer: William Saunders
Division of Long-Term Care Experimentation

Description: The purpose of this demonstration is to expand the alternative long-term care delivery model Assessment for Community Care Services (ACCESS) developed for the Medicaid population in Monroe County, New York, to include the county's Medicare population. The addition of this Medicare project is for the purpose of working toward an integration of Medicare and Medicaid long-term care services.

Status: The project began operations in October 1982. The Health Care Financing Administration has contracted with New York Blue Cross to serve as Medicare fiscal intermediary for the demonstration. Thus far, more than 2,400 Medicare beneficiaries with potential long-term care needs have received assessments from the project. The demonstration has been extended until 1986 to evaluate the project's effects on the health care system in Monroe County.

Home Services for Functionally Disabled Adults

Project No.: 18-P-97462/2-03
Period: June 1980 - June 1984
Funding: \$ 488,075
Grantee: Community Service Society
Institute for Social Welfare Research
105 East 22nd Street
New York, N.Y. 10010
Project Officer: Marni Hall
Division of Economic Analysis

Description: Functionally disabled, low-income adults are being followed for 12 months after acute hospitalization to determine the impact of ongoing home service programs. Access to services, quality of services delivered, participation of informal supports, quality of circumstances, durability of independent living arrangements, and public costs will be examined. Data for this project include survey data and Medicare and Medicaid expenditure data.

Status: All of the data for this project have been gathered and the grantee is reconciling the expenditure data from various sources and matching it with respondent service reports. Initial findings from preliminary data analyses indicate that the majority (60 percent) of the disabled elderly in this study were discharged from hospitals without having home services arranged for them by the hospitals. The hospitals in this study used their limited resources to arrange for suitable placements of institution-bound patients rather than those who were being discharged to their homes.

New York State's Long-Term Home Health Care Program

Project No.: 11-P-97155/2-05
Period: September 1978 - March 1984
Funding: \$ 225,688
Grantee: New York State Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Description: This program provides an alternative to institutionalization for Medicaid clients who meet the medical criteria for skilled nursing facilities (SNF's) or intermediate care facilities (ICF's). A maximum expenditure for home care has been set at 75 percent of the going rate in a locale for SNF or ICF levels of care for which the client is eligible. The program objectives include promoting cost containment by reducing fragmentation in the provision of home care services through a single entry system that coordinates and provides these services.

Status: Currently there are over 30 provider sites in operation. The Health Care Financing Administration approved the project's fifth and final year through March 1984. The final year allows time to complete reassessments, prepare a final report, transmit data to the evaluator, and expand the program statewide under the authority of Section 2176 (Home and Community-Based Services Program). In December 1982, the program began statewide expansion. HCFA expects to receive the State's final report by the end of March 1984.

Evaluation of New York State's Long-Term Home Health Care Program

Project No.: 500-79-0052
Period: September 1979 - March 1984
Funding: \$ 742,694
Contractor: Abt Associates, Inc.
55 Wheeler Street
Cambridge, Mass. 02138
Project Officer: Kathy Ellingson
Evaluative Studies Staff

Description: The Long-Term Home Health Care Program (LTHHCP) is designed to offer coordinated comprehensive home health care services through a single health care provider to Medicaid-eligible aged or disabled individuals in need of skilled nursing or health-related facility care. The major evaluation objective is to determine whether or not the LTHHCP provides an alternative to institutional care in terms of cost, service use, and health outcome. The research is designed to identify 700 program participants and 700 comparison participants, and follow the individuals for at least 1 year by collecting cost and utilization data and applying a health assessment instrument at three points in time. The data being collected are for Medicare, Medicaid, food stamps, energy assistance, public assistance, and supplemental security income. The final analysis will compare total public expenditures for the program participants to those of the comparison population, with measures of health status outcome for both groups.

Status: A descriptive analysis of the program was completed in March 1983. This report is the case study portion of the final report due in Spring 1984.

South Carolina Community Long-Term Care Project

Project No.: 99-P-97493/4-04
Period: September 1979 - December 1984
Grantee: South Carolina Department of Social Services
P.O. Box 1520
Columbia, S.C. 29202-9988
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Description: Through Medicaid and Medicare waivers, the State is conducting a demonstration in three counties to test community-based client assessment, coordination of services, and provision of alternative services. It is anticipated that these waivers will increase the use of home care services, thereby reducing reliance on hospitals and lowering the incidence of conversion from Medicare to Medicaid in nursing homes.

Status: The project currently has 651 experimental clients and 535 control group clients. In September 1983, the Health Care Financing Administration approved the State's request for a 15-month continuation through December 1984. The State began implementation of the Medicare waivers in Spring 1983. The project is conducting an internal evaluation to determine the cost-effectiveness of community-based services in meeting the needs of the elderly. In November 1983, the project submitted a preliminary report to HCFA on the first year cohort after 18 months of project participation. This report indicates that the project is targeting on a functionally impaired population whose Medicaid costs are less than the Medicaid costs for the control group. A final evaluation report is expected in Winter 1985.

Modifications of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged

Project No.: 11-P-97473/6-05
Period: January 1980 - December 1985
Grantee: Texas Department of Human Resources
706 Banister Lane
Austin, Tex. 78769
Project Officer: Michael J. Baier
Division of Long-Term Care Experimentation

Description: The purpose of this project is to reduce the growth of nursing homes in Texas and, at the same time, expand access to community care services for needy Medicaid individuals. It is being accomplished by directly changing the operating policies of the State's Title XIX and XX programs; in particular, by eliminating the State's lowest level of institutional care--intermediate care facility (ICF) II. Existing organizations responsible for the State's Title XIX and XX programs are responsible for project implementation.

Status: The project is in its fifth year. Of the 15,486 individuals in the "Intermediate Care Facility-II Cohort" group in March 1980, only 6,710 or 43 percent, were still receiving ICF-II services as of June 30, 1983. The total nursing home population also decreased 12 percent from March 1980 to June 30, 1983, from 64,643 clients to 56,790 clients. In February 1983, a monthly average of 42,500 individuals were receiving community-based services, up 12.5 percent from 37,200 in March 1980. An estimated 3 out of every 4 community-care recipients qualified for the institutional care services that were available before the program was restructured.

Long-Term Care Demonstration Project of North San Diego County

Project No.: 95-P-97325/9-04
Period: September 1979 - January 1984
Funding: \$ 1,063,463
Grantee: Allied Home Health Association, Inc.
4525 Mission Gorge Place
San Diego, Calif. 92120
Project Officer: Michael J. Baier
Division of Long-Term Care Experimentation

Description: The purpose of the project is to demonstrate that a Medicare-certified provider of home health services is an appropriate and cost-effective resource for the administration of a long-term care system. The project is comparing client benefits and costs between existing long-term care services and those provided under the project for 500 Medicare beneficiaries. Case-management and client-assessment services are provided by the grantee, and waived services are provided by 19 suppliers of health and social services.

Status: The project officially ended January 15, 1984. Contract services to all experimental clients ended on September 30, 1983, with case management services being available through October 30, 1983. No significant problems were encountered in terminating clients from the project. The grantee's final report is expected in April 1984.

Delivery of Medical and Social Services to the Homebound Elderly: A Demonstration of Intersystem Coordination

Project No.: 18-P-97492/2-03
Period: November 1979 - March 1984
Funding: \$ 599,358
Grantee: New York City Department for the Aging
280 Broadway
New York, N.Y. 10007
Project Officer: Michael J. Baier
Division of Long-Term Care Experimentation

Description: The purpose of the project is to document the characteristics of a homebound elderly population in New York City, assess their health care needs, and estimate the costs of delivering needed care. A coordinated health care delivery model has been established to carry out this project on behalf of the 400 experimental Medicare clients. The project organization includes a project advisory committee that is comprised of representatives of relevant city departments, and four neighborhood-based service delivery sites.

Status: The project is in its third and final year and is scheduled to terminate on March 31, 1984. On April 1, 1983, the project began discharging clients for whom it was able to arrange alternate services in the community. As of December 1983, approximately 100 of the original 400 experimental clients still remained in the project. Contract services to all experimental clients ended on February 15, 1984, with case management services being available through March 31, 1984. A final project report is expected in Spring 1984.

Long-Term Care Demonstration Design and Development

Project No.: 95-P-97231/9-04
Period: September 1978 - December 1983
Funding: \$ 1,280,021
Grantee: Mt. Zion Hospital and Medical Center
1600 Divisadero Street
San Francisco, Calif. 94120
Project Officer: William Saunders
Division of Long-Term Care Experimentation

Description: The Mt. Zion Hospital and Medical Center completed this Medicare demonstration that implemented a hospital-based, long-term care services delivery system in a designated service area in San Francisco, Calif. This model built upon components of Mt. Zion's existing geriatric services program. A consortium of five service providers under the direction of Mt. Zion cooperated to provide a range of health and social services to the frail elderly in the designated catchment area.

Status: The project received waivers to permit provision of certain health-related and social services that are not otherwise provided under Medicare. The project provided services to more than 200 participants. After an 8-month winddown period, the operational phase of the project ended on June 30, 1983. In December 1983, the project submitted for HCFA review a final report describing the demonstration and its findings.

Ancillary Community Care Services: A Health Care System for Chronically Impaired Elderly Persons

Project No.: 11-P-97438/4-04
Period: October 1979 - March 1984
Grantee: Florida Department of Health and Rehabilitative Services
1317 Winewood Boulevard
Tallahassee, Fla. 32301
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Description: The State is conducting a Medicaid demonstration project in five counties. The purpose of the project is to develop and test ancillary community care services for the chronically impaired elderly 60 years of age and over. All eligible clients receive a comprehensive medical-social assessment administered by a physician and social worker. The participating counties are responsible for developing client-care plans based on the assessment, conducting case management, and contracting for services with local providers.

Status: The total number of project participants is 971, with 761 randomly assigned to the experimental group and 210 assigned to the control group. All sites reached full caseload by June 1982. The project is currently in its final year. In April 1983, the project sites began working with community agencies to develop an orderly plan for transferring clients from the project to the existing service delivery system. In May 1983, the State submitted an interim report describing the project's research design and base-line data. The final evaluation report is expected to be submitted in April 1984.

Systematic Examination of Factors that Promote Home Care by the Family

Project No.: 18-P-98385/5-01
Period: September 1983 - September 1986
Funding: \$ 393,153
Grantee: Abbott Northwestern Hospital, Inc.
Planning and Marketing Dept.
800 East 28th Street at Chicago Avenue
Minneapolis, Minn. 55407
Project Officer: Marni Hall
Division of Economic Analysis

Description: The primary purpose of this project is to describe the role of urban and rural family members in providing home care to frail and chronically-ill relatives. It will assess the impact that formal support systems, such as health and social services, have on the promotion of home care. Detailed data will be collected on the caregiving experiences of families of persons meeting the study criteria of advanced age, impairment, living in a private home, and family contacts.

Status: During the initial period of this grant, members of the advisory group were selected for the project and appropriate consultants were enlisted. Also, the research design was refined and plans were made for selecting a sample of hospitalized chronically-ill elderly.

Respite Care Co-Op for Impaired Elderly

Project No: 18-P-98398/5-01
Period: September 1983 - September 1986
Funding: \$ 128,880
Grantee: Southcentral Michigan Commission on Aging
2401 E. Milham Road
Kalamazoo, Mich. 49002
Project Officer: Jean L. Bainter
Division of Long-Term Care Experimentation

Description: This feasibility study is expected to develop a model cooperative to provide respite for family caregivers of impaired elderly. Family members pay for care with care given. The objectives are to study the feasibility and cost of developing a model cooperative designed to prevent exhaustion of family members, to eliminate the need for more intensive and/or expensive care, and to prevent unnecessary institutionalization of the elderly.

Status: The project is in the early stages of development. The evaluation contractor came on board in March 1984.

On Lok's At-Risk, Capitated Payment Demonstration

Project Nos.: 95-P-98246/9-01
11-P-98334/9-01
Period: November 1983 - November 1986
Grantees: On Lok Senior Health Services
1441 Powell Street
San Francisco, Calif. 94133
and
California Department of Health Services
714-744 P Street
Sacramento, Calif. 95814
Project Officer: Jean L. Bainter
Division of Long-Term Care Experimentation

Description: The Health Care Financing Administration granted Medicare waivers to the On Lok Senior Health Services and Medicaid waivers to the California Department of Health Services to permit On Lok to implement a 3-year at-risk, capitated payment demonstration. Building on On Lok's already established and operating Community Care Organization for Dependent Adults, this new demonstration will modify On Lok's reimbursement mechanism, and all services to the frail and elderly population will be paid for by a predetermined capitated rate from both Medicare and Medicaid (Medi-Cal).

Status: A contract has been signed between On Lok and the California Department of Health Services to permit a Medi-Cal capitated payment to On Lok. Medicare's reimbursement is based on the adjusted average per capita cost with all participants in the ratebook's institutionalized cells. On Lok is assuming total risk under both Medicare and Medi-Cal. For those who are not covered by one or both of these programs, a copayment system has been developed and is being implemented.

Swing Bed

Reducing Acute Care Costs

Project No.: 600-75-0207
Period: July 1975 - September 1983
Funding: \$ 148,535
Contractor: Blue Cross of Western Iowa and South Dakota
Hamilton Boulevard at I-29
Sioux City, Iowa 51102
Project Officer: Tom Kickham
Division of Long-Term Care Experimentation

Description: This project is a swing-bed demonstration that seeks to reduce a hospital's acute care costs while alleviating two problems prevalent in many rural communities: low occupancy rates in the hospital and a shortage of long-term care beds. Essentially, the experiment allows a hospital to use existing staff and facilities to render both acute and long-term care.

Status: Based on the results of swing-bed demonstrations, legislation was introduced in Congress and enacted as part of the Omnibus Reconciliation Act of 1980 (Public Law 96-499) to permit reimbursement of swing-bed care in rural hospitals with less than 50 beds. Regulations implementing this legislation were published on July 20, 1982. Waivers were extended until November 20, 1982, to allow participating hospitals to meet the requirements of the legislation. The contract was extended until September 30, 1983, to allow Blue Cross time to make final settlements with the demonstration swing-bed hospitals.

Quality

Improving New York State's Nursing Home Quality Assurance Program

Project No.: 11-P-97590/2-03
Period: September 1980 - March 1986
Grantee: State of New York Department of Social Services
Tower Building Empire State Plaza
Albany, N.Y. 12237
Project Officer: Elizabeth S. Cornelius
Division of Long-Term Care Experimentation

Description: This project tests the simplification of federally mandated periodic medical review/independent professional review processes in nursing homes and combines the process with the annual facility survey. Surveyors use 11 sentinel health events (SHE), such as accidents, decubitus ulcers, and medication regimen to determine if nursing home patients are receiving quality care. Facilities found to have fewer than the average problems in these areas receive a less than full facility survey. This combined medical review and survey method reduces surveyors' time and allows State personnel to focus on facilities and patients with major problems.

Status: The project is currently in its third year. The new inspection-of-care processes are fully operational. The State has indicated that it is taking more legal actions than usual as a result of the new processes, but that fewer facilities are being cited for minor problems. During the fourth year, the project staff will continue to monitor the implementation of the new methods and integrate them with the new survey process. Also, the State will develop a detailed evaluation plan to test the validity of using these outcomes of care as an indicator of poor quality.

Quality Assurance Sampling: A Statistical Quality-Control Approach to Inspection of Care

Project No: 11-P-98260/1-01
Period: March 1983 - February 1986
Grantee: Massachusetts Department of Public Welfare
600 Washington Street
Boston, Mass. 02111
Project Officer: Elizabeth S. Cornelius
Division of Long-Term Care Experimentation

Description: The main objective of the project is to verify that patients in nursing homes are receiving appropriate care at the appropriate level, without reviewing every patient. Current law requires a review of all patients in a facility to verify the appropriateness of care and placement. This project will use statistical quality control techniques to achieve these goals so that surveyor time can be reallocated to other quality-assurance activities.

Status: Criteria have been developed for determining which facilities are appropriate for the sampling process. The procedures for sampling patients, including safeguards to control statistical biases, have been refined. Pre-tests of the process and orientation sessions for surveyors were conducted in July and August 1983. The project became operational on August 29, 1983.

Evaluation of Three-State Demonstration in Nursing Home Quality Assurance

Project No.: 500-82-0024
Period: August 1982 - August 1984
Funding: \$ 662,113
Contractor: Mathematics Policy Research
905 University Avenue
Room 203
Madison, Wis. 53715
Project Officer: Spike Duzor
Evaluative Studies Staff

Description: This is an evaluation of the three-State demonstration testing new procedures for conducting nursing home facility surveys and patient quality of care determinations. The States participating in this demonstration include Wisconsin, New York, and Massachusetts.

Status: The contractor is currently collecting data to measure the results of the survey process in nursing homes that were surveyed using the new methods and a group of comparison homes where the old survey methods were used. A final report is expected in September 1984.

Data Development and Analyses

Interagency Agreement for Long-Term Care Survey of Individuals in Households

Project No.: IAA-82-0159
Period: October 1981 - September 1984
Funding: \$ 975,000
Contractor: Assistant Secretary for Planning and Evaluation
Department of Health and Human Services
Room 415-F Hubert Humphrey Bldg.
200 Independence Avenue, S.W.
Washington, D.C. 20201
Project Officer: Allen Dobson
Office of Research

Description: This project was initiated to provide information on functionally-limited elderly individuals living in households. A sample of 35,000 aged persons was drawn from the Health Care Financing Administration's Health Insurance Master File and was screened by telephone or personal visits to identify individuals having functional limitations for a period of 3 months or longer. The 6,400 functionally-limited persons so identified were interviewed to ascertain information on their limitation, on the formal and informal network supporting them, and on their income.

Status: Data collection was completed in October 1982. Weighted analytic data files became available in March 1984. A planned series of reports will provide: the number, distribution, and the demographic and functional characteristics of disabled persons in households; sources and nature of support in carrying out the activities of daily living; income and assets; and use of medical services.

Long-Term Care Residential Services for Developmentally Disabled People

Project No.: 18-P-98078/5-03
Period: September 1981 - September 1984
Funding: \$ 1,166,635
Grantee: University of Minnesota
207 Pattee Hall
150 Pillsbury Drive, S.E.
Minneapolis, Minn. 55455
Project Officer: Marni Hall
Division of Economic Analysis

Description: This project will update the only national information system on long-term care services for the mentally retarded and developmentally disabled (MR/DD). Data will be gathered on characteristics of residents and facilities, including intermediate care facilities for the mentally retarded (ICF-MR's). Data from this study will be used to track the effects of recent State deinstitutionalization policies. As part of the project, policy analyses of the cost/utilization of Medicaid MR/DD services are made. These analyses focus on: financing of residential care; case mix and movement of residents; and programs, services, and manpower.

Status: National surveys of residential facilities and State statistical offices have been conducted and the data are currently being analyzed. Important policy analyses are underway, including longitudinal, descriptive analyses of the changes in the long-term care system for MR/DD people between 1977 and 1983, and analysis of Medicaid's changing role in the MR/DD area, including changes in the client population, the nature of ICF-MR's and their costs. An analysis has been completed of 26 States' responses to Section 2176, Public Law 97-135, as it impacts on the MR/DD population. The findings indicated that:

- Almost 62 percent of the States studied planned to serve the MR/DD population under the 2176 waiver program.
- As a result of the waiver, 7 of the 16 States with programs aimed at the MR/DD group felt that they would be able to reduce the number of institutional beds. In contrast, programs for the elderly under this waiver generally stressed diversion of new admissions rather than closing down beds.
- In general, most States planned to move the MR/DD population to less intensive types of long-term-care facilities under this program. In most cases, the States did not foresee return to the client's home as a possibility.
- Case management was the service most often included in States' waiver requests. For the MR/DD group, rehabilitation services were the second most frequently requested service.
- Case-management systems are already in place and are better developed for the MR/DD population than for the elderly.
- Almost all of the States with MR/DD plans cover a large portion of the costs of services provided to recipients in residential care, although the costs of room and board are not allowable under the waiver.

AFDC Home Health Aides

AFDC Homemaker/Home Health Aide Demonstration

Period: January 1982 - June 1986
Project Dennis M. Nugent
Officer: Division of Long-Term Care Experimentation

Description: Recipients of Aid to Families with Dependent Children (AFDC) are trained and employed as homemaker/home health aides to provide services to elderly or disabled individuals who, without this support, would require institutionalization. The objectives of the demonstration are to reduce welfare dependency and to prevent or delay the institutional placement of the eligible service clients. This study will measure the costs and benefits of the program, including its contribution to the improvement in employment and earnings capacity of the AFDC recipient and the reduction in the need for institutional care of the functionally impaired home care service client.

Status: Seven States are participating in this demonstration which initiated its 3-year operational segment on January 1, 1983. During the first year, the States began the recruitment and training of the AFDC recipients who had volunteered to take part in the project. As of November 1983, 1,096 of these volunteers had successfully completed the training phase of the demonstration. Many of these AFDC recipients are providing home care services to the 1,371 elderly and/or disabled clients who have been identified throughout the first year as being at risk of institutionalization.

A Plan for Employing AFDC Recipients as Homemaker/Home Health Aides to Provide Alternatives to Long-Term Care

Project No.: 12-P-98110/6-02
Grantee: Arkansas Department of Human Services
P.O. Box 1437
Little Rock, Ark. 72203

Preventacare: An Alternative to Institutionalization

Project No.: 12-P-98111/4-02
Grantee: Kentucky Cabinet for Human Resources
CHR Building, Sixth Floor West
275 East Main Street
Frankfort, Ky. 40621

AFDC Homemaker/Home Health Aide Demonstration Project

Project No.: 12-P-98113/2-02
Grantee: New Jersey Department of Human Services
Capitol Place One
222 South Warren Street
Trenton, N.J. 08625

New York State AFDC Homemaker/Home Health Aide Demonstration

Project No.: 12-P-98103/2-02
Grantee: New York State Department of Social Services
40 North Pearl Street, 7th Floor
Albany, N.Y. 12243

Employment Opportunities for AFDC Recipients in the Homemaker/Home Health Aide Field

Project No.: 12-P-98106/5-02
Grantee: Ohio Department of Public Welfare
30 East Broad Street, 31st Floor
Columbus, Ohio 43215

Homemaker/Home Health Aide Project

Project No.: 12-P-98108/4-02
Grantee: South Carolina Department of Social Services
P.O. Box 1520
Columbia, S.C. 29202

AFDC Recipients as Providers of Services to Aged and Disabled

Project No.: 12-P-98104/6-02
Grantee: Texas Department of Human Resources
522-A, P.O. Box 2960
Austin, Tex. 78769

Design Development and Evaluation of the AFDC Homemaker/Home Health Aide Demonstration Project

Project No.: 500-82-0022
Period: June 1982 - June 1986
Funding: \$ 454,174
Contractor: Abt Associates, Inc.
55 Wheeler Street
Cambridge, Mass. 02138
Project Officer: Kathy Ellingson
Office of Demonstrations and Evaluations

Description: The purpose of this project is to evaluate the Aid to Families with Dependent Children (AFDC) Homemaker/Home Health Aide demonstration and to provide technical assistance to the seven States participating in the demonstration. The actual evaluation will occur under separate contracts with the seven participating States. A final report to HCFA will be based on the State evaluations. The three major evaluation objectives are to:

- Assess the costs and effectiveness of the training and employment of AFDC recipients as homemakers/home health aides on subsequent, continued, and unsubsidized employment.
- Assess the costs and outcomes of providing home health aid services to persons at risk of institutionalization who would otherwise not receive these services.
- Assess the net cost effectiveness and provide policy-relevant projections on large-scale implementation.

Status: The contractor has completed four major deliverables: a data resources report; a report on issues in the design implementation; the final research design; and the first year report, "Planning and Initial Implementation Experience." This report is a descriptive analysis of the seven States' first year activity. Individual State case studies were also completed. A second year annual report will be completed June 1984.

Comparison by State of SNF/ICF Types: Beds, Staffing, Utilization, and Ownership

Funding: Intramural
Project Elizabeth S. Cornelius
Director: Division of Long-Term Care Experimentation

Description: This project unduplicated the count of skilled nursing facilities (SNF's), intermediate care facilities (ICF's), and respective beds for 1981. The facility and bed count are based on the Medicare/Medicaid Automated Certification System (MMACS) data as of May 31, 1981. Full-time equivalents for registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, pharmacists, qualified social workers, and dietitians have also been identified. A staffing matrix showing the relationship to current staffing regulations was developed. In addition, a staffing matrix, using number of beds to nurse staffing ratios will be tested. This project is being conducted in conjunction with a project funded by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services, which will evaluate the usefulness of the MMACS system for research and policy analysis purposes. The intramural analysis will examine State-by-State differences in:

- Types of certified, long-term care facilities (SNF only, SNF/ICF combination, ICF only).
- Number of beds per facility.
- Professional staffing levels.

The analysis will also identify the percent of total certified beds used by Medicare, Medicaid SNF, and Medicaid ICF, during fiscal year 1981.

Status: The ASPE evaluation has been completed, and the final report has been accepted by the Department. The evaluation found that the staffing data are acceptable for a State-level analysis. An unduplicated tape has been prepared and tables have been constructed. The staffing data has been cross checked with the Master Facility Inventory file maintained by the National Center for Health Statistics, and a research file at Columbia University.

Other Long-Term Care

Bioactuarial Estimates and Forecasts of Health Care Needs and Disability

Project No.: 18-P-97710/4-03
Period: June 1980 - August 1984
Funding: \$ 428,650
Grantee: Duke University
2117 Campus Avenue
Durham, N.C. 27706
Project Officer: Paul W. Eggers
Division of Beneficiary Studies

Description: This project employs bioactuarial methods to estimate the need for various types of health services including long-term care. The determinations of levels of need are employed in analyses of the health status of small geographic areas as well as in national projections. The project is also examining how need estimates are being translated into utilization of nursing homes. These applications of bioactuarial strategies for forecasting population change in health status represent an extension of the grant's basic work.

Status: Results of this project include estimates and projections of the incidence and prevalence of specific chronic diseases (for example, cancer) among the elderly population. In addition, the study has provided new insights on the flow of the elderly population through the nursing home system (for example, admission rates and lengths of stay). Finally, the project is developing profiles of the elderly population in terms of the likelihood of their using alternative modes of long-term care. The National Medical Care Utilization and Expenditure Survey and the Long-Term Care Survey, both Health Care Financing Administration funded efforts, have had this methodology applied to them. Currently, 16 publications have been written under this grant.

- "Use of Grade of Membership Analysis to Evaluate and Modify Diagnosis-Related Groups."
- "A Dynamic Model of Population Aging and Health Status Change: Implications for the Development and Implementation of National Health Policy."
- "Analytic Approaches for Determining Incidence from Prevalence and Reported Disease Duration."
- "An Analysis of the Heterogeneity of U.S. Nursing Home Patients."
- "The Economic Impact of Health Policy Intervention."
- "The Application of Disease Specific Models for Health Trend Projections."
- "Modeling Health States Change Among the Oldest Old."
- Forecasting Chronic Disease Morbidity Patterns."

- "Estimating the Long-Term Care Population and Its Use of Services."
- "Compartment Model Methods in Estimating Costs of Cancer."
- "Strategies for Collating Diverse Scientific Evidence in the Analysis of Population Health Characteristics: Bioactuarial Models of Chronic Diseases for the Elderly."
- "Life Table Methods for Assessing the Dynamics of Nursing Home Utilization: 1976-77."
- "Projecting Chronic Disease Prevalence."
- "The Characteristics and Utilization Pattern of An Admission Cohort of Nursing Home Patients (I)."
- "The Future Growth of the Long-Term Care Population: Projections Based on the 1977 National Nursing Home Survey and the 1982 Long-Term-Care Survey."
- "The Characteristics and Utilization Patterns of an Admission Cohort of Nursing Home Patients (II)."

Impact of State Discretionary Policies

Project No.: 18-P-97620/9-03
 Period: March 1980 - December 1983
 Funding: \$ 917,268
 Grantee: Aging Health Policy Center
 University of California
 3rd and Parnascus
 San Francisco, Calif. 94143
 Project Officer: Marni Hall
 Division of Economic Analysis

Description: This is a study of discretionary State policies in Medicare/Medicaid, Title XX, and Supplemental Security Income as they affect long-term care (LTC) services for the aged. Particularly important in the research are the effects that actual or perceived fiscal crisis has on long-term care services. By comparing various States' LTC policies, data about optional approaches to containing LTC costs will be obtained.

Status: All of the data gathering for this project has been completed. Personal interviews and a telephone survey of State officials and providers were important sources of information. A report that compares policies among the 8 study States has been prepared. This study covers a period in which States' orientation to Medicaid and social service budgets changed from continuous expansion to fiscal restraint. While the major findings pertain to the detailed changes in each State, and will be elaborated upon in the final report, the following generalizations are supported by the data:

- General fiscal condition explained many of each State's program changes over the period. States without severe economic crises made few changes in Medicaid and social services.
- Despite differences in economic conditions, States maintained the same rank order in program generosity. The States with more generous programs remained so.
- States used various means to achieve fiscal control, including changes in eligibility, benefits, reimbursement, and administrative procedures. Reimbursement changes were expected to achieve the most savings.

The final report for this project is due in Spring 1984.

Comparison of the Cost and Quality of Home Health and Nursing Home Care

Project No.: 18-P-97712/8-03
Period: June 1980 - May 1985
Funding: \$ 1,282,283
Grantee: University of Colorado
4200 East 9th Avenue
Denver, Colo. 80262
Project Officer: Philip Cotterill
Division of Economic Analysis

Description: This study assesses the cost, quality, and cost-effectiveness of nursing home and home health care provided by free-standing agencies and hospital-based facilities. Detailed data on patient conditions and services were collected for a sample of nursing home and home health patients from the following States: Arkansas, California, Colorado, Florida, Michigan, Minnesota, New York, Ohio, Pennsylvania, and Virginia. A subset of patients will be tracked over time to observe outcomes.

Status: During the third year, additional data on Medicare patients in skilled nursing facilities (SNF's) were collected so that case-mix comparisons could be made between Medicare and non-Medicare patients in hospital-based and freestanding facilities. The University of Colorado sampled 600 patients in high volume Medicare SNF's in five States (California, Pennsylvania, Ohio, Michigan, and Texas), and 600 non-Medicare patients in hospital-based and freestanding nursing homes in 10 States (Arkansas, California, New York, Michigan, Minnesota, Colorado, Florida, Virginia, Pennsylvania, and Ohio). From these studies of case-mix differences, the following patterns emerge:

- Medicare patients are more seriously ill from a medical perspective and possess greater rehabilitation potential than other long-term care patients.
- Non-Medicare patients tend to be more dependent in functions, as measured by activities of daily living (ADL's), and have more traditional long-term care problems (impaired mobility, depression, mental problems).
- These differences between Medicare and other patients exist for both hospital-based and freestanding SNF's, but they are more pronounced for hospital-based SNF's.
- In general, patients in hospital-based nursing homes tend to be more dependent in ADL's, have more traditional long-term care problems, and have more medically oriented problems than do patients in freestanding nursing homes.
- This pattern of differences between hospital-based and freestanding patients is more pronounced for non-Medicare than for Medicare patients.
- Further evidence from these studies indicates that these case-mix differences are responsible for differences in resource consumption. Medicare patients and hospital-based patients are more costly to treat than other patients. Unfortunately, we cannot precisely quantify the size of these differences with existing data.

Hospital-based nursing patients tend to have more medical problems and fewer psychosocial problems than do patients in freestanding nursing homes. These results apply largely to Medicaid patients. Case-mix comparisons of Medicare and non-Medicare patients are in progress.

Pursuit of Institutional Alternatives

Project No.: 18-P-98188/4-01
Period: December 1982 - June 1984
Funding: \$ 242,478
Grantee: North Carolina Health Care Facilities Association
5109 Bur Oak Circle
Raleigh, N.C. 27612
Project Officer: Marni Hall
Division of Economic Analysis

Description: This study explores the potential participation of North Carolina nursing homes in alternative institutional programs that provide services to the elderly. Alternative programs being examined include home health care, adult day care, and nutritional services. The legal, organizational, financial, and facility resource requirements will be identified. This project will also assess the changes in demand for noninstitutional long-term care services as a result of the Medicaid home and community-based waivers authorized under Section 2176 of the Omnibus Budget Reconciliation Act of 1981, and will conduct a preliminary evaluation of this waiver program in the State.

Status: In the initial year of this project, all North Carolina nursing homes were surveyed to determine their interest in providing noninstitutional services, and a report was prepared of the findings. Significant progress was made toward the development of capital budgeting models for use by nursing homes interested in expanding their services. In addition, arrangements were made to obtain the data needed to analyze the first year's operation of the Section 2176 home and community-based waiver program. Planned activities include a followup survey of those nursing homes that have implemented or planned to implement new noninstitutional services, and greater refinement and application of the capital budgeting models. Preliminary results indicated that most of the surveyed nursing homes were interested in offering at least one type of health service to nonresidents. Twenty percent of the responding homes offered at least one service at the time they were surveyed. Physical therapy and meals were the most frequently offered services, although significant numbers of nursing homes indicated interest in offering a variety of services to nonresidents. Only about 12 percent were not interested in offering at least one service. Nursing homes were more likely to be interested in delivering services to non-residents if these services were to:

- Fill the gap in availability or adequacy of existing services.
- Be cost effective and/or profitable for the organization.
- Be accepted by physicians in the community.
- Require no substantial changes in management structure.

Encouraging Appropriate Care for the Chronically Ill Elderly: A Controlled Experiment to Evaluate the Impacts of Incentive Payments on Nursing Home Admissions, Discharges, Case Mix, Care, Outcomes, and Costs

Project No.: 11-P-97931/9-03
Period: April 1981 - April 1985
Grantee: State of California Department of Health Services
714 P Street
Sacramento, Calif. 95814
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Description: This project is testing a system of monetary incentives as a means of encouraging skilled nursing facilities (SNF's) in San Diego to admit and provide quality care to severely dependent patients. Many patients have more lengthy hospital stays than appropriate because of the amount and cost of care these patients would require in an SNF. Health Care Financing Administration waivers permit SNF rates which exceed the Medicaid cost limits by the incentive amounts. National Center for Health Services Research (NCHSR) provides total project funding.

Status: Preliminary results are mixed. The proportion of Type E patient admissions (patients requiring special nursing, such as comatose care) to treatment group SNF's rose from 6.8 percent to 11 percent, and the proportion of Type E admissions to control group SNF's dropped slightly from 6.1 percent to 5.7 percent. Type D admissions (those dependent in all six activities of daily living) remained unchanged for both treatment and control groups. The NCHSR final evaluation report is projected for late 1984.

Effects of Alternative Family Support Strategies

Project No.: 95-P-98281/0-01
Period: May 1983 - April 1986
Funding: \$ 396,531
Grantee: University of Washington
Long Term Care Center
Institute on Aging
Seattle, Wash. 98195
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Description: The purpose of this project is to study the effects of support programs provided to families that care for their elderly members at home. The demonstration will assess the impact of three support strategies: paid respite care, family training and case management, and a combination of respite care with training and case-management. Key outcome variables to be measured are family burden, length of time families serve as primary care givers, propensity toward institutionalization, and cost of long-term care services.

Status: This project completed its developmental phase in December 1983. Families began receiving services in January 1984.

Analysis of Long-Term Care Payment Systems

Project No.: 18-P-98306/8-01
Period: April 1983 - June 1987
Funding: \$ 1,358,011
Grantee: Center for Health Services Research
University of Colorado
4200 East 9th Avenue
Denver, Colo. 80262
Project Officer: Philip Cotterill
Division of Economic Analysis

Description: This project is a comparative analysis of long-term care reimbursement systems in seven States. The study will combine an empirical analysis of nursing home costs and payments and the determinants of costs with a detailed qualitative analysis of the operations of the reimbursement systems. The comparative analysis across States will be performed through a unique "comparison-by-substitution" method that calculates reimbursement for nursing homes in one State under the assumption that the other States' reimbursement systems are in effect. Data sources for this study include primary facility information and patient samples, as well as secondary sources such as cost reports.

Status: Work to date has focused on review of State nursing home reimbursement systems and refinement of the study's research design. The States to be included in the study have been selected. They are Arkansas, Colorado, Florida, Maryland, Ohio, Utah, and West Virginia.

Long-Term Care of Aged Hip Fractures: Public versus Private Costs

Project No.: 18-P-98393/3
Period: September 1983 - September 1986
Funding: \$ 537,678
Grantee: University of Maryland Medical School
655 West Baltimore Street
Baltimore, Md. 21201
Project Officer: Judith Sangl
Division of Economic Analysis

Description: This study is examining, in detail, the complex economic and psychosocial determinants of the public and private contribution to the long-term care of a group of aged individuals who suddenly become disabled by hip fractures. The impact of family size and composition, social support, family economic resources, and the aged individual's physical and mental health will be analyzed in terms of the decision to enter a nursing home or return home.

Status: This project began in October 1983.

Responsibility of Children for Financing Institutional Care: Potential Response and Possible Adjustments

Project No.: 18-P-98375/1-01
Period: November 1983 - March 1985
Funding: \$ 80,000
Grantee: Hebrew Rehabilitation Center for the Aged
1200 Centre Street
Boston, Mass. 02131
Project Officer: Judith Sangl
Division of Economic Analysis

Description: The objective of this project is to determine the barriers to and potential for alternate payment schemes for long-term care, particularly nursing home care, by the children of the elderly. The research will:

- Provide an estimate of children's resources available to share in the costs of long-term care.
- Assess the attitudes of those children toward proposals for sharing in the costs of their parents' long-term care and identify factors associated with those who have positive and negative feelings.
- Assess the market for a new type of insurance for nursing home care, and identify factors associated with those who are and are not interested in such insurance.

Status: This project began in November 1983.

Can Geriatric Nurse Practitioners Improve Nursing Home Care?

Project No.: 18-P-98379/9-01
Period: September 1983 - December 1986
Funding: \$ 573,760
Grantee: The Rand Corporation
1700 Main Street
Santa Monica, Calif. 90406
Project Officer: Judith Sangl
Division of Economic Analysis

Description: The purpose of the study is to evaluate the potential of the use of geriatric nurse practitioners (GNP) for improving outcomes of care and containing costs in skilled nursing facilities. Thirty nursing homes that participated in the Mountain States Health Corporation's GNP demonstration project will be compared with 30 nursing homes in the region that did not participate. Comparisons will be made of:

- Patient outcomes.
- Process of care.
- Nursing home costs.
- History of certification deficiencies.

Homes will be matched by State, ownership, bed size, and urban, suburban, or rural location.

Status: The start of the project was delayed until December 1983 when joint funding was arranged with the Robert Wood Johnson Foundation and the Kellogg Foundation. A majority of the homes in the sampling frame have been contacted and have agreed to participate.

Case-Managed Medical Care for Nursing Home Patients

Project No.: 95-P-98346/1-01
Period: July 1983 - July 1986
Grantee: Massachusetts Department of Public Welfare
600 Washington Street
Boston, Mass. 02111
Project Officer: Jean L. Bainter
Division of Long-Term Care Experimentation

Description: The Health Care Financing Administration granted Medicare and Medicaid waivers to the Massachusetts Department of Public Welfare to permit fee-for-service reimbursement for the provision of medical services by physician-supervised nurse practitioners/physician assistants for 6,500 residents of nursing homes. This will permit increased medical monitoring that is expected to generate cost savings as a result of fewer hospital admissions and hospital outpatient visits. The evaluation will examine the effects of the program on expenditures, the quality of care, and the cost implications of carrying out the program on a large scale.

Status: The early phase of this project has been one of startup and of marketing the concept to other providers (individual physicians and groups) and to nursing home administrators. In addition, the matched control group of 12 nursing homes for the Urban Medical Group has been selected.

ALTERNATIVE PAYMENT SYSTEMS

Competition

A Demonstration of Cost Control and Patient Satisfaction Resulting from the Relaxation of the Maximum Public Enrollment Rule for HMO's

Project No.: 11-P-97986/5-02
Period: April 1981 - March 1984
Grantee: Michigan Department of Social Services
300 South Capitol Avenue
P.O. Box 30037
Lansing, Mich. 48909
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: The purpose of this demonstration is to test the effects on the cost and quality of care in health maintenance organizations (HMO's) resulting from the relaxation of the regulation requiring that Medicare and Medicaid beneficiaries cannot exceed 75 percent of total HMO enrollment. The project will compare the quality of care provided in HMO's exceeding the limit with HMO's conforming to the regulation through the use of satisfaction surveys.

Status: The project has developed a survey instrument modeled after the one used in the Prepaid Health Research, Evaluation, and Demonstration project (Project No. 96-P-90299/9). The survey questionnaire measures patient satisfaction in relation to seven health care dimensions, in addition to demographics and health care expenses. The State is in the process of evaluating the survey results.

Competitive Bidding for Clinical Laboratory Services

Project No.: 500-82-0054
Period: September 1982 - March 1984
Funding: \$ 188,979
Contractor: Center for Health Policy Studies
5865 Robert Oliver Place
Columbia, Md. 21045
Project Officer: Diane L. Rogler
Division of Hospital Experimentation

Description: The purpose of this 18-month contract was to develop the materials necessary for Medicare to test the use of competitive bidding for the purchase of non-inpatient laboratory services. The contract involved a mini-market study to collect and evaluate information about the laboratory industry from three sites, followed by a series of papers addressing the various issues which are important to the design of a bidding system. These include monopoly concerns, freedom of choice, which laboratory services are appropriate for bidding, how the bidding system could be administered, and which patient populations should be involved.

Status: The Center for Health Policy Studies has submitted a mini-market study report, a series of issue papers, a comprehensive description of the bidding systems, an implementation strategy report, the draft documents to be used in soliciting bids, and an evaluation issues report. The Center's materials also address how a contractual fee schedule could be implemented. A final report for the project is expected in Spring 1984.

Test of the Out-of-Pocket Cost Savings as an Incentive for Changing Beneficiary Choice Behavior

Project No.: 18-P-98392/3-01
Period: September 1983 - September 1986
Funding: \$ 709,316
Grantee: Morgan State University
Institute for Urban Research
Baltimore, Md. 21239
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: The project is designed to develop basic knowledge on how elderly health care consumers obtain and process information, and how they balance various factors when making decisions under Medicare. The project has four objectives:

- To investigate ways of making beneficiaries more cost conscious.
- To examine the impact of information on expected out-of-pocket costs on beneficiary choice and behavior.
- To devise optimal approaches for beneficiaries to use in approaching their providers.
- To train beneficiaries in these techniques and test their effect.

Status: The grantee has refined the research design, formalized subcontract relationships, and begun the identification and collection of background data.

American Association of Retired Persons' Informed Buyer Program

Project No.: 18-P-98391/3-01
Period: September 1983 - September 1985
Funding: \$ 256,080
Grantee: American Association of Retired Persons
1909 K Street, N.W.
Washington, D.C. 20049
Project Officer: Kathleen Farrell
Division of Health Systems and Special Studies

Description: This demonstration project is designed to sensitize health maintenance organizations (HMO's) to offer an improved benefit package for the Medicare-eligible population. This will be accomplished in six sites by educating and training older volunteer health advocates about the HMO option and by assisting these advocates in persuading the HMO's to offer a benefit package attractive to Medicare beneficiaries. In addition, a community-wide education program will be implemented to inform Medicare beneficiaries about the HMO option and how to compare it with other health care options, and to encourage them to review their current coverage in light of this new information.

Status: This demonstration is in the developmental phase. A project manager has been hired and the selection of sites has begun.

Medicare Competition Projects

Medicare Prospective Capitation Demonstration Project

Project No.: 95-P-98147/4-02
Period: April 1982 - March 1986
Grantee: International Medical Centers, Inc.
1505 NW. 167th Street
Miami, Fla. 33169
Project Officer: John Sirmon
Division of Health Systems and Special Studies

Description: This project will demonstrate and test an alternative to traditional Medicare financing and health care delivery in Miami. The health maintenance organization (HMO) will provide covered Medicare benefits for an amount of reimbursement equal to 95 percent of the adjusted average per capita cost. Extra benefits are being offered to Medicare beneficiaries at little or no cost, including dental benefit, eyeglasses, hearing aides, prescription drugs, and transportation to the HMO.

Status: Preparation for implementation of the demonstration proceeded from April through July 1982. On August 1, 1982, more than 10,000 Medicare beneficiaries were enrolled in the demonstration. These beneficiaries were already enrolled in a Health Care Financing Administration sponsored Section 1876 risk contract. Since that time, International Medical Centers (IMC) has averaged more than 2,000 new members per month. As of December 1, 1983, IMC had 40,544 members. Among the operational problems that have arisen, IMC was having difficulty in negotiating arrangements with area hospitals. IMC has now selected a different claims processing option that allows the intermediary to pay claims from those hospitals with which IMC cannot arrange an agreement. This project is scheduled for implementation through December 31, 1985, and IMC expanded from the present two counties (Dade and Broward) to other counties within the State of Florida effective January 1, 1984. The expansion counties include Palm Beach to the north and Hillsborough, Pasco, Manatee, and Pinellas to the northwest (Tampa).

Enrollment of Medicare Beneficiaries Under a Unique Intra-Health Maintenance Organization Competition Model

Project No.: 95-P-98215/4-02
Period: September 1982 - August 1986
Grantee: CAC Health Plan, Inc.
P.O. Box 013140
Miami, Fla. 33101
Project Officer: Kathleen Farrell
Division of Health Systems and Special Studies

Description: This project will demonstrate and test an alternative to traditional Medicare financing and health care delivery in Miami. The health maintenance organization (HMO) will provide covered Medicare benefits and several extra benefits for an amount of reimbursement equal to 95 percent of the adjusted average per capita cost. A unique feature of the HMO is an enrollee privilege to seek out-of-plan physician services subject to a deductible and copay amount.

Status: The design phase, including protocol, waiver approval, service agreement development and approval, and marketing material approval was completed within 30 days of the grant award and the first enrollees in CAC became effective October 1, 1982. As of December 1, 1983, there were 3,167 Medicare enrollees in the plan. The plan offers extensive benefits in addition to Medicare, with no monthly premium. The service agreement is in effect through December 31, 1986.

Replication of Minnesota Health Care Financing Administration/Share Medicare Demonstration in Chicago

Project No.: 95-P-98445/5-01
Period: September 1983 - September 1986
Grantee: Share Development Corporation
3600 West 80th Street
Bloomington, Minn. 55431
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: The purpose of this project is to replicate the Share experience of Minneapolis/St. Paul in Chicago. Share-Illinois will operate primarily as a hospital-based, individual practice association model, health maintenance organization with several group model components. The protocol design phase is expected to be completed by Spring 1984 and operations are projected to commence during the summer. Share will be accepting 95 percent of the adjusted average per capita cost and is expected to offer an expanded benefits package with a monthly premium and token copays.

Status: A design protocol was submitted in December 1983 and is presently being reviewed by Office of Demonstrations and Evaluations staff. Share anticipates enrollment will begin in July 1984.

Waiver Only Competition Project for Southern California, Illinois, Indiana, and Texas

Project No.: 95-P-98342/9-01
Period: June 1983 - May 1988
Grantee: Maxicare Health Plans, Inc.
11633 Hawthorne Boulevard
Hawthorne, Calif. 90250
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: Maxicare Health Plans, Inc. is a for-profit, federally qualified, independent physicians' association model, health maintenance organization based in Hawthorne, California, serving five counties in Southern California as well as areas around Chicago, Illinois, Indianapolis, Indiana, and Houston, Texas. Four sites will be phased in over a 1-year period at 6-month intervals. Maxicare plans to evaluate enrollment/disenrollment, utilization, cost, and quality. The project would last 60 months and involve a total of approximately 50,000 Medicare beneficiaries (out of a total 215,000 enrollees across the four sites) enrolled in a prepaid health care program.

Status: Maxicare intends to start enrolling Medicare beneficiaries under this prospective capitation in Los Angeles, and Chicago, April 1984; in Texas and Indiana, November 1984. A draft protocol was submitted October 1983.

Medicare Competition Demonstration

Project No.: 500-82-0037
Period: September 1982 - September 1987
Contractor: Av-Med, Inc.
9400 S. Dadeland Boulevard
Miami, Fla. 33156
Project Officer: Kathleen Farrell
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Miami. Av-Med is a federally qualified, individual practice association model, health maintenance organization (HMO), that has a 5-year contract to implement a full-risk prepaid capitation demonstration project in Dade and Broward Counties, Florida. Av-Med is accepting 95 percent of the adjusted average per capita cost and is providing an expanded benefit package with no monthly premium. Av-Med has more than 100 independent practice physicians participating in the demonstration. The HMO intends to enroll at least 5,000 Medicare beneficiaries during each year of the demonstration. They also expanded to other Florida counties in 1984.

Status: Av-Med began Medicare demonstration enrollment on November 1, 1982. The entire design phase, that is, protocol development, waivers approval, service delivery contract development and approval, marketing material approval, and implementation of systems changes was completed within 30 days. As of December 1, 1983, more than 5,600 Medicare beneficiaries were enrolled. Av-Med expanded to Tampa (counties of Hillsborough, Manatee, Pasco, and Pinellas) and north to Palm Beach County in January 1984.

Medicare Competition Demonstration

Project No.: 500-82-0050
Period: September 1982 - September 1987
Funding: \$ 363,524
Contractor: Family Health Program, Inc.
9930 Talbert Avenue
Fountain Valley, Calif. 92708
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This is a project designed to develop and test an alternative model for financing and delivering health care services to Medicare beneficiaries living in southern Los Angeles County and Orange County, Calif. Family Health Program (FHP) is a federally qualified health maintenance organization (HMO) which proposed to compete for area beneficiaries by making available an attractive benefit package. FHP plans to demonstrate that a clinical facility, designed specifically for a Medicare population, will improve quality of care and is cost effective. Reimbursement will be based on 95 percent of the adjusted average per capita cost.

Status: FHP has enrolled more than 7,500 Medicare beneficiaries since marketing activities began in September 1983. This demonstration is unique in that FHP has constructed a multi-service health care center designed specifically for Medicare beneficiaries. FHP offers two options to beneficiaries--a basic and extended benefit package. The basic plan, which has no monthly premium requirements, covers all Medicare benefits plus preventive services and prescriptions with small copayments. The extended package, offered for a \$35 monthly premium, also covers refractions, eyeglasses, podiatry, and dental care and eliminates copayments for basic services. Of the enrollees, 15 percent selected the high option.

Medicare Competition Demonstration

Project No.: 500-82-0043
Period: September 1982 - September 1987
Contractor: Watts Health Foundation
10300 Compton Avenue
Los Angeles, Calif. 90002
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This is a project designed to test an alternative model for enhancing competition among providers of care. United Health Plan (UHP) will implement a competitive demonstration through a contract with the Health Care Financing Administration (HCFA) to provide Medicare beneficiaries in the Los Angeles-Orange County area with a comprehensive set of benefits covering physician services, hospitalization, and other medical services. Reimbursement for services will be prospectively determined on a capitation basis. UHP will also provide all administrative, marketing, quality assurance, and utilization control functions required under this contract.

Status: UHP has signed a contract and has been granted waivers by HCFA for the operation of a Medicare competition demonstration project in the Los Angeles area. The waivers will permit prospective reimbursement and the delivery of additional benefits offered to Medicare beneficiaries. Watts will receive reimbursement at 95 percent of what Medicare would normally pay in the fee-for-service system. The project will begin delivery of services in April 1984. UHP plans to enroll 3,000 Medicare beneficiaries in the first operational year and to expand to 10,000 beneficiaries by the third year of the demonstration. Traditionally, those who have been served by the UHP are the categorically eligible for Medicaid. The mixing of public beneficiaries from Medicaid and Medicare in a largely publicly funded HMO provides a unique aspect for this demonstration.

Medicare Competition Demonstration

Project No.: 500-82-0049
Period: September 1982 - September 1987
Funding: \$ 232,835
Contractor: Blue Cross of California
P.O. Box 7000
Van Nuys, Calif. 91409
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in the Santa Barbara area. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing will be on a risk basis. Two alternatives will be tested including a preferred provider arrangement.

Status: This project is in its developmental phase. Blue Cross of California has contacted various provider organizations to determine if they will participate. Blue Cross anticipates the project will be implemented by September 1984.

Medicare Competition Demonstration

Project No.: 500-82-0051
Period: September 1982 - September 1987
Funding: \$ 980,646
Contractor: Health Choice, Inc.
621 S.W. Alder Street
Suite 820
Portland, Oreg. 97205
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in the Portland area. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost (AAPCC). Financing will be on a risk basis. Health Choice will establish itself as a broker for Medicare beneficiaries in the county. As broker, it would market to beneficiaries and counsel them as to which alternative health plans (AHP's) are available and what benefits each offers. Health Choice would subcontract to assist organizations in establishing themselves as AHP's.

Status: This project is in its developmental phase. A conference was held in January 1983 with potential provider organizations who would accept risk reimbursement at 95 percent of the AAPCC. Three to five health plans are expected to participate. Marketing is scheduled to begin September 1984.

Medicare Competition Demonstration

Project No.: 500-82-0042
Period: September 1982 - September 1987
Contractor: Maricopa County Department of Health Services
2601 East Roosevelt
Phoenix, Ariz. 85008
Project Officer: Sidney Trieger
Division of Health Systems and Special Studies

Description: The Maricopa County Department of Health Services (MCDHS) has established an Alternative Health Plan, which is enrolling Medicaid eligibles under the Arizona Health Care Cost-Containment System. MCDHS plans to offer enrollment also to Medicare beneficiaries. They will receive payment from Medicare at 95 percent of the adjusted average per capita cost.

Status: The MCDHS intends to provide a comprehensive range of benefits, including nursing services, typically associated with long-term care and not covered by Medicare. The project submitted a draft protocol in August 1983, and has a projected start date of September 1984.

Medicare Competition Demonstration

Project No.: 500-82-0046
Period: September 1982 - September 1987
Funding: \$ 565,047
Contractor: Harvard Community Health Plan
One Fenway Plaza
Boston, Mass. 02215
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in the Boston area. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing will be on a risk basis. Harvard Community Health Plan is a successful, federally qualified, staff model, health maintenance organization (HMO) that has been operational since 1969. It is one of 14 HMO's in the project area. It plans to enroll 7,200 Medicare beneficiaries by the end of the demonstration. Benefits competitive with Medigap will be offered at lower premiums.

Status: This project is in its developmental phase. The project is scheduled to begin enrollment June 1984.

Medicare Competition Demonstration

Project No.: 500-82-0045
Period: September 1982 - September 1987
Funding: \$ 531,360
Contractor: Blue Cross of Massachusetts
100 Summer Street
Boston, Mass. 02106
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Massachusetts. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing will be on a risk basis. Under this demonstration, Blue Cross of Massachusetts will establish a Senior Plan Network of four, and possibly five health maintenance organizations (HMO's) in the State. Each HMO will compete with at least one other in its area.

Status: Blue Cross of Massachusetts began enrolling beneficiaries in October 1983. Initial enrollment (6,000 beneficiaries) for two of the plans was double the plans' projections.

Medicare Competition Demonstration

Project No.: 500-82-0033
Period: September 1982 - September 1987
Contractor: Rhode Island Group Health Association
530 North Main Street
Providence, R.I. 02904
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in the Rhode Island area. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing will be on a risk basis. This project is with an 11-year old, federally qualified health maintenance organization that serves 35,000 members in parts of Rhode Island and Southeast Massachusetts. It currently has a cost contract under which 2,000 Medicare beneficiaries are enrolled.

Status: This project is in its developmental phase. The contractor is preparing a protocol and expects to begin enrollment by June 1984.

Medicare Competition Demonstration

Project No.: 500-82-0032
Period: September 1982 - September 1987
Contractor: U.S. Health Care Systems Health Maintenance Organization
of Pennsylvania
2500 Maryland Road
Willow Grove, Pa. 19090
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: This project will demonstrate and test an alternative to traditional Medicare financing and delivery of health care services in the Philadelphia metropolitan area. The demonstration is a large, established, federally qualified, individual practice association model, health maintenance organization (HMO) that serves 105,000 enrollees in the Philadelphia area, including 1,000 Medicare eligibles under a cost contract. The HMO plans to enroll 7,000 beneficiaries under this project and will be reimbursed at 95 percent of the adjusted average per capita cost after a 24-month developmental phase. Case management, quality assurance, and benefit package enhancement will be emphasized. Seven counties in Pennsylvania and six in New Jersey will be included. An expanded benefits package, including ambulatory, diagnostic, laboratory/radiology, preventive, vision care, annual physical evaluation, skilled nursing facilities, and home care, is to be offered on a capitation basis as an incentive to attract the Medicare beneficiaries.

Status: Currently, HMO of Pennsylvania has been enrolling Medicare beneficiaries under their cost contract with great success. A protocol describing the demonstration program has been delayed but will be submitted in Spring 1984.

Medicare Competition Demonstration

Project No.: 500-82-0034
Period: September 1982 - September 1987
Contractor: Metropolitan Health Council of Indianapolis
931 East 86th Street
Suite 200
Indianapolis, Ind. 46240
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Indianapolis. The demonstration is being conducted by a federally qualified, staff model, health maintenance organization (HMO) with an enrollment of 52,000 members, including 1,000 Medicare beneficiaries previously enrolled under a cost contract. The HMO is using one large teaching hospital exclusively for its Medicare enrollees and is implementing a risk-sharing arrangement with the hospital under which the hospital will receive a flat percentage of the adjusted average per capita cost (AAPCC). The Metro Health Plan (MHP) wants to test the cost effectiveness of competing for Medicare beneficiaries' enrollment in their plan based on offering an expanded package of benefits including preventive and dental on a prospective capitation reimbursement system. The premium is \$28.60 a month.

Status: MHP started enrolling Medicare beneficiaries under this prospective capitation arrangement in January 1984. Current enrollment in the demonstration is 1,800 with all 1,000 cost-contract beneficiaries converting and 800 new members joining.

Medicare Competition Demonstration

Project No.: 500-82-0047
Period: September 1982 - September 1987
Funding: \$ 730,959
Contractor: Health Care Network, Inc.
20800 Greenfield
Oak Park, Mich. 48237
Project Officer: Kathleen Farrell
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Detroit. Health Care Network (HCN), owned by Blue Cross of Michigan, is a group model operating in Detroit, a competitive community. HCN is offering a "Medinet" program for Medicare beneficiaries through a network of 25 primary care physician groups (PPG) composed of 8 to 25 physicians in each PPG. HCN will include measures for sharing risk for the network for referral services and hospital costs. Enrollees are required to use HCN-approved hospitals.

Status: The protocol was approved in December 1983 and the demonstration became operational in January 1984.

Medicare Competition Demonstration

Project No.: 500-82-0038
Period: September 1982 - September 1987
Contractor: Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Mich. 48226
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Detroit. The project will accept 95 percent of the adjusted average per capita cost from the Health Care Financing Administration for Medicare beneficiaries enrolled in the Detroit area. It will then contract with preferred provider organizations, starting with Detroit Medical Center, to serve beneficiaries at favorable rates. Beneficiaries will not be locked into obtaining services through the plan but will be allowed to seek services outside the plan provided they are willing to pay the traditional Medicare deductibles and coinsurance. This project will experiment with the concept that the financial incentives of no coinsurance or deductibles when services are received through plan providers will be sufficient to keep beneficiaries within the plan.

Status: This project is in its developmental phase. The plan has submitted a draft protocol and is in the process of making revisions. The scheduled implementation date is June 1984.

Medicare Competition Demonstration

Project No.: 500-82-0039
Period: September 1982 - September 1987
Contractor: Group Health Plan of Southeast Michigan
5700 Crook Road
Troy, Mich. 48099
Project Officer: Kathleen Farrell
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Detroit. The demonstration will involve a federally qualified, staff model, health maintenance organization (HMO) that has been in operation since 1977. It serves 24,000 enrollees in the Detroit area, of which 2,000 are enrolled under a Medicaid risk contract. The HMO plans to enroll 1,000 Medicare beneficiaries a year under the demonstration to a total of 3,500.

Status: The protocol for this demonstration was approved in December 1983. The demonstration became operational in February 1984.

Medicare Competition Demonstration

Project No.: 500-82-0040
Period: September 1982 - September 1987
Contractor: Senior Health Plan
315 Iris Park Place
1885 University Avenue
Minneapolis, Minn. 55104
Project Officer: John Sirmon
Division of Health Systems and Special Studies

Description: This project involves the formation and testing of a new entity, a joint venture between St. Paul-Ramsey Medical Center, Amherst H. Wilder Foundation, and Health Central, Inc. This consortium will provide comprehensive medical and institutional services to an enrolled population, and will provide benefits additional to the standard Medicare package, particularly in long-term care. Extensive use of cost sharing is proposed to control utilization. HCFA is considering incorporating a modification to the standard adjusted average per capita cost (AAPCC) reimbursement method. Prior hospital utilization and Medicare Part B utilization would be used in conjunction with current AAPCC factors to derive prospective rates for each plan member.

Status: This project is nearing its operational phase. HCFA has approved senior health plans protocol and marketing material. Waiver packages and service agreements are currently being drafted. It is anticipated the demonstration project will be operational in May 1984.

Medicare Competition Demonstration

Project No.: 500-82-0041
Period: September 1982 - September 1987
Contractor: Affiliated Professionals, Inc.
One Parkland Boulevard
Suite 1002 West
Dearborne, Mich. 48126
Project Officer: John Sirmon
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in two cities. Affiliated Professionals (APRO) is a health maintenance organization (HMO) management firm. APRO proposes to create a new Medicare-only HMO with enrollment at two sites--Detroit, Michigan, and Champaign, Illinois--with large teaching hospital participation. APRO will receive payments from the Health Care Financing Administration and disburse funds to the sites.

Status: This project is nearing its operational phase. HCFA has approved APRO's protocol and marketing material. Waiver packages and service agreements are currently being drafted. It is anticipated the demonstration project will be operational in April 1984.

Medicare Competition Demonstration

Project No.: 500-82-0044
Period: September 1982 - September 1987
Contractor: Capital Area Community Health Plan
1201 Troy Schenectady Road
Latham, N.Y. 12110-1076
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in the Albany area. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing will be on a risk basis. Capital Area Community Health Plan is a federally qualified, staff model health maintenance organization (HMO) operating in a tri-city service area of Albany, Schenectady, and Troy, New York. The HMO has had a Medicare cost contract since 1978.

Status: This project is in its developmental phase. Capital Area anticipates initiating enrollment in Spring 1984.

Medicare Competition Demonstration

Project No.: 500-82-0030
Period: September 1982 - September 1987
Contractor: American Medical Care and Review Association
5410 Grovesnor Lane
Bethesda, Md. 20814
Project Officer: Kathleen Farrell
Division of Health Systems and Special Studies

Description: The purpose of this Medicare competition demonstration is to develop and test alternative models of financing and/or delivering health care for Medicare beneficiaries that enhance competition. The American Medical Care and Review Association, a trade association of individual practice association model, health maintenance organizations (HMO's), is conducting a capitation demonstration to test a unique component that involves the establishment of a pooled risk reserve to cover any losses of the HMO's. There are 7 original member plans, with eventual expansion to 15 projects. Each will be reimbursed at 95 percent of the adjusted average per capita cost.

Status: Three of the seven original member plans are operational: Genesee Health Care of Flint, Michigan; Central Massachusetts Health Care of Worcester, Mass.; and South Florida Group Health of Miami, Fla. The remaining four member plans will be operational in April 1984. These plans are Delmarva Health Care of Easton, Md.; Choicecare of Cincinnati, Ohio; Crossroads Health Plan of East Orange, N.J., and Marion HMO of Marion, Ohio. Seven additional plans have applications pending for membership in the demonstration.

Medicare Competition Demonstration

Project No.: 500-82-0035
Period: September 1982 - September 1987
Contractor: Health America Corporation
3310 West End Avenue
Nashville, Tenn. 37203
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This project will demonstrate and test alternative health plans in several cities. Health America Corporation is a national health maintenance organization (HMO) management firm that owns or manages 13 HMO's. The demonstration will be conducted at eight sites. The participating plans are:

- HealthCare of Broward (Miami)).
- Health Service Plan of Pennsylvania (Philadelphia).
- Health America of Ohio (Cleveland).
- Rockridge Health Plan (Oakland).
- Pima Care of Arizona (Tucson)
- Penn Group (Pittsburgh)
- Health Care, Inc. (Atlanta)
- Health America of Florida (Tampa)

Each plan will contract with the Health Care Financing Administration directly. The reimbursement will be 95 percent of the adjusted average per capita cost for the service areas involved.

Status: One of the plans, HealthCare of Broward, became operational on February 1, 1983. The design phase, including protocol, waiver approval, service agreement signature, marketing, and systems changes, was completed for an effective date of February 1, 1983. More than 1,000 Medicare beneficiaries were enrolled as a result of their transfer from a HealthCare of Broward cost contract. The HealthCare of Broward service agreement will be in effect through December 31, 1986. As of December 1983, there were 2,064 Medicare enrollees in the Broward plan. The other seven plans are expected to become operational during 1984.

Medicare Competition Demonstration

Project No.: 500-82-0048
Period: September 1982 - September 1987
Contractor: Group Health Plan of Greater St. Louis
10822 Sunset Plaza
St. Louis, Mo. 63127
Project Officer: John F. Meitl
Division of Health Systems and Special Studies

Description: Group Health Plan of Greater St. Louis is a federally qualified, staff model, health maintenance organization (HMO) with a cost contract with the Health Care Financing Administration. The plan is in a designated competitive area with six other HMO's. Reimbursement under this project will be 95 percent of the adjusted average per capita cost. A risk pool for physicians will be established and the plan has reinsurance. The project will include a comparative evaluation of selected marketing approaches and determine if HMO membership has the potential to reduce service utilization.

Status: The Group Health Plan of Greater St. Louis submitted a draft protocol in late February 1984 and plans to hold open enrollment in mid-1984.

Medicare Competition Demonstration

Project No.: 95-P-98337/2-01
Period: June 1983 - May 1987
Grantee: Westchester Community Health Plan
145 Westchester Avenue
White Plains, N.Y. 10601
Project Officer: John Sirmon
Division of Health Systems and Special Studies

Description: The Westchester Community Health Plan (WCHP) is a federally qualified, staff model, health maintenance organization (HMO) that has been operational since 1976 in suburban New York City. There are 115,000 residents 65 years of age or over in Westchester County, of which 800 Medicare beneficiaries have enrolled in a Section 1876 cost contract with WCHP that has been in effect since 1977. The plan currently has 20,000 enrollees. WCHP will receive 95 percent of the adjusted average per capita cost and will assume full risk for providing a comprehensive package of services.

Status: The plan has initiated development of the protocol and development of premium rates. The plan anticipates initiating enrollment under the risk contract by June 1984.

Medicare Competition Demonstration

Project No.: 95-P-98256/2-01
Period: February 1983 - January 1987
Grantee: Genesee Valley Group Health Association
41 Chestnut Street
Rochester, N.Y. 14647
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: Genesee Valley Group Health Association (GVGHA) is a 10-year-old federally qualified, health maintenance organization (HMO) located in Rochester, N.Y. Group Health is competing for area beneficiaries by offering an expanded benefit package at a low premium of \$15.00 per month with a lock-in provision. The HMO will accept 95 percent of the adjusted average per capita cost. Group Health had a cost contract and planned to convert 1,240 of these beneficiaries into the demonstration. Overall enrollment in GVGHA is 35,000, of which 80 percent are enrolled through commercial groups.

Status: GVGHA submitted a draft operational protocol and marketing materials in June 1983. GVGHA started marketing activities in September 1983, enrolling 1,130 Medicare beneficiaries in October 1983, as well as converting 1,240 beneficiaries from their cost contract, and offering their services December 1983.

Medicare Competition Demonstration

Project No.: 95-P-98340/9-01
Period: June 1983 - May 1987
Grantee: French Hospital Medical Center
4131 Geary Boulevard
San Francisco, Calif. 94118
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: The purpose of the project is to test a hospital-based health maintenance organization (HMO) model designed to enhance competition in the San Francisco area and provide increased choice for Medicare beneficiaries. French will accept reimbursement at 95 percent of the adjusted average per capita cost and will offer an enriched benefit package. Projected enrollment is 6,000. The project will also study quality of care by examining severity of disease for HMO enrollees at the time of admission to acute care hospitals to determine whether the HMO's pattern of continuity of care results in less severe morbidity at admission.

Status: The project submitted an operational protocol in December 1983. French Hospital anticipates an open enrollment period beginning in April 1984 with a May 1984 effective date.

Medicare Competition Demonstration

Project No.: 95-P-98338/0-01
Period: June 1983 - May 1987
Grantee: Group Health Service Plan d.b.a. Healthcare
1800 I Street
Sacramento, Calif. 95814
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: The Group Health Service Plan is a federally qualified, group practice model, health maintenance organization (HMO) serving 15,000 enrollees in Sacramento. The Plan has been State-certified since 1978 and currently holds a Medi-Cal contract with 5,000 enrollees. The proposed demonstration will be similar in most respects to other Medicare competition demonstrations. Healthcare will enroll beneficiaries on a voluntary basis and will be reimbursed at 95 percent of the adjusted average per capita cost. Among its goals, Healthcare plans to demonstrate that preventive health care and health promotion programs and the delivery of health services by health care professionals, other than physicians, such as physician assistants, are effective and well received by Medicare beneficiaries.

Status: The project completed its operational protocol, which was approved by the Health Care Financing Administration. Healthcare projects to enroll 1,800 beneficiaries in its first operational year, which is scheduled to begin May 1984.

Medicare Competition Demonstration

Project No.: 95-P-98339/8-01
Period: June 1983 - May 1987
Grantee: Presbyterian/St. Luke's Health Plan
1601 East Nineteenth Avenue
Denver, Colo. 80218
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: The project will test the preferred provider organization (PPO) concept for Medicare beneficiaries. The PPO will offer comprehensive Medicare benefits in Denver and seven other Colorado counties. The project will contract with the Health Care Financing Administration for 95 percent of the adjusted average per capita cost. Contracting will be on a risk basis. The plan will offer continuous open enrollment and anticipates enrolling 15,000 beneficiaries by the end of 3 years. Beneficiaries will be locked into the health plan.

Status: This project is in its developmental phase. Operations are scheduled to begin June 1984. An operational protocol, currently under development, must be approved by the Health Care Financing Administration before operation may begin.

Development, Implementation, and Management of Medicare Competition Demonstrations

Project No.: 500-83-0005
Period: November 1982 - May 1984
Funding: \$ 275,000
Contractor: Birch and Davis Associates, Inc.
8905 Fairview Road
Silver Spring, Md. 20910
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: This contractor provides technical support for the Medicare competition demonstrations. Institutional surveys will be conducted to establish the adjusted average per capita costs (AAPCC) for the alternative health plans located in States where the Medicaid agencies are unable to furnish the required information. AAPCC's will be computed using a methodology approved by the Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy, Health Care Financing Administration, and an actuarial consultant. Essential support will continue to be provided throughout the demonstration by means of task orders.

Status: Institutional surveys have been conducted in 10 States. Birch and Davis completed 118 AAPCC calculations for demonstrations in 18 States. By April 1984, Birch and Davis expects to complete another 70 AAPCC calculations for demonstrations in 11 States.

Alternative Models for Prepaid Capitation of Health Care Services for Medicare Beneficiaries in the Twin Cities Area

Project No.: 500-78-0081
Period: September 1978 - November 1983
Funding: \$ 927,709
Contractor: Interstudy, Inc.
5715 Christmas Lake Road
Excelsior, Minn. 55331
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This demonstration is testing competition among four health maintenance organizations (HMO's) for Medicare enrollees in the seven-county Twin Cities area of Minnesota. Interstudy has applied a broker concept to initially market the four plans and each HMO is being reimbursed at 95 percent of the adjusted average per capita cost, using the ratebook approach. Each HMO is competing for the target population through the use of increased benefits, reduced cost sharing, and public education.

Status: This contract had a design phase (September 1978 - September 1980) in which the operational issues and waivers were detailed. In October 1980, the four participating HMO's each signed an implementation agreement with the Health Care Financing Administration (HCFA) to be effective through December 31, 1983. As of December 1983, enrollment in the demonstration reached 31,661: Share Health Plan (21,190), MedCenter (6,213), HMO Minnesota (2,990), and Nicollet/Eitel (1,268). Approximately 1,900 enrollees in Share were formerly under a HCFA cost contract. In July 1982, the Share Health Plan was granted authority to operate in an eighth county (St. Louis), approximately 200 miles northeast of the Twin Cities area. HCFA has granted a 2-year extension of the operational program through December 31, 1985. In addition, Share Health Plan and HMO Minnesota have been authorized to operate in three additional counties (Sherborne, Stearns, and Wright) beginning January 1, 1984. A fifth HMO, Group Health Plan, Inc., has been added to the Twin Cities demonstration, effective May 1983. It is anticipated that operations will begin in Spring 1984.

Alternative Models for Prepaid Capitation Financing of Health Care Services for Medicare

Project No.: 500-80-0062
Period: September 1978 - June 1983
Funding: \$ 311,438
Contractor: Marshfield Medical Foundation
510 North St. Joseph's Avenue
Marshfield, Wis. 54449
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project tested prepaid health care delivery to Medicare beneficiaries in the Marshfield, Wis., area. The project had a risk contract with the Health Care Financing Administration (HCFA) and was reimbursed on a capitated amount less than the adjusted average per capita cost (AAPCC). The benefits offered under the demonstration included all regular Medicare benefits and extra benefits ordinarily included by Marshfield in its supplementary package. Renal beneficiaries were enrolled under a separate, higher capitation rate.

Status: This project completed its operational phase in September 30, 1982, at which point nearly 9,000 beneficiaries were enrolled in the demonstration project. A final report has been received. Marshfield experienced major financial losses under this demonstration. During most of the demonstration, HCFA participated in a reinsurance agreement to cover losses resulting from hospital utilization in excess of that covered by the AAPCC.

Alternative Models for Prepaid Capitation of Health Care Services for Medicare Recipients--Massachusetts

Project No.: 500-78-0082
Period: September 1978 - December 1983
Funding: \$ 698,843
Contractor: Fallon Community Health Plan
425 Lake Avenue North
Worcester, Mass. 01605
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This prospective risk capitation Medicare health maintenance organization demonstration is testing a reimbursement methodology based on an adjusted community rate, with a cap established at 95 percent of the adjusted average per capita cost in its area. Savings will be returned to beneficiaries in the form of increased benefits and reduced cost sharing. A variety of marketing approaches are being tested for effectiveness.

Status: This project completed its third operational year. As of January 1984, Fallon participated with three other health maintenance organizations in a demonstration project sponsored by Blue Cross of Massachusetts. Fallon's current enrollment stands at approximately 9,000. The Plan offered its enrollees eyeglasses, prescription drugs, and low monthly premium rates. The evaluation of this project is scheduled to be completed in 1984.

Alternate Models for Prepaid Capitation of Health Care Services for Medicare Recipients--Oregon

Project No.: 500-78-0078
Period: September 1978 - December 1983
Funding: \$ 1,044,160
Contractor: Kaiser Foundation
Health Services Research Center
4610 Southeast Belmont Street
Portland, Oreg. 97215
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This prospective risk capitation, Medicare health maintenance organization demonstration is testing a reimbursement methodology based on 95 percent of the adjusted average per capita cost in the Kaiser Portland/Oregon region. The savings between the capitation rate and the adjusted community rate will be returned to the beneficiaries in the form of increased benefits, reduced cost sharing, or both. A variety of marketing approaches are being tested.

Status: This project has had 3 years of operational experience. Enrollment currently stands at approximately 8,000. The project is scheduled to operate until July 1984. Kaiser will continue its demonstration project as part of the HealthChoice, Inc. demonstration in Portland, Oreg. The completed evaluation of the project is expected in 1984.

Alternate Models for Prepaid Capitation of Health Care Services for Medicare Recipients--Michigan

Project No.: 500-78-0079
Period: September 1978 - May 1984
Funding: \$ 290,861
Contractor: Blue Cross and Blue Shield of Michigan (Health Central)
600 Lafayette East
Detroit, Mich. 48226
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This prospective risk capitation project is designed to test the effectiveness of a prepaid plan offering additional benefits and reduced cost sharing. The project was designed to test the ability of a newly federally qualified, health maintenance organization (HMO) to enroll the Medicare and Medicaid population in Ingham, Eaton, and Clinton counties of Michigan (Lansing area). The HMO involved is Health Central, an affiliate of Blue Cross/Blue Shield of Michigan. An actuarial method is used to set the capitation amount. Thus far, the Health Care Financing Administration's payments have been less than 95 percent of the adjusted average per capita cost amounts on fee-for-service costs.

Status: The design phase was completed by October 1981 and enrollment began in November 1981. An attempt to include Medicaid in the demonstration failed when the State and the HMO could not agree upon reimbursement levels for services. Although slow in achieving their goal of 2,000 Medicare enrollees, they are continuing their efforts to provide a comprehensive benefit package for General Motors (GM) retirees in the area. GM constitutes a significant portion of the retirees in that area. Health Central offered its program to GM retirees in August 1983. As of December 1983, there were 1,152 enrollees. The reimbursement phase of the demonstration was scheduled to terminate in December 1983, and Health Central planned to convert the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) contract in January 1984. Since the regulations implementing TEFRA were delayed, this project was extended through June 30, 1984.

Evaluation of Health Maintenance Organization (HMO) Capitation Demonstrations

Project No.: 500-81-0017
Period: February 1981 - August 1984
Funding: \$ 2,272,672
Contractor: Jurgovan and Blair, Inc.
51 Monroe Street
Rockville, Md. 20850
Project Officer: Alan Friedlob
Evaluative Studies Staff

Description: This evaluation examines the experience of eight health maintenance organizations (HMO's) who have contracted with the Health Care Financing Administration (HCFA) under a prepaid, at-risk basis to provide services to Medicare beneficiaries. These demonstrations are the precursors of current legislation contained in the Tax Equity and Fiscal Responsibility Act of 1982, Section 114. The evaluation's objectives are:

- To measure HMO versus fee-for-service differences in utilization patterns for Medicare beneficiaries, standardizing for population differences.
- To assess the accuracy of HCFA's method of estimating what HMO enrollees would have cost under fee-for-service (that is, for the adjusted average per capita cost or AAPCC).
- To measure the extent to which either favorable or adverse selection has occurred, and the cost impact of selection bias in enrollment.
- To assess the cost effectiveness of different marketing methods to the Medicare beneficiary population.
- To assess the fiscal impact of the demonstrations for HCFA, for the HMO, and for beneficiaries.
- To examine the organizational changes in both the administrative and delivery systems conditioned by the addition of seniors to HMO membership.
- To analyze the implications of the demonstrations for national policy.

Status: An actuarial critique of the AAPCC was completed in April 1982. A survey of Medicare beneficiaries who joined the plans and those who chose not to enroll has been completed in Marshfield, Wis., Worcester, Mass., and Minneapolis-St. Paul, Minn. Survey findings are available. A report examining rate-setting issues has been completed, as has a monograph examining the operational issues facing HMO's and competitive medical plans contemplating risk-based Medicare contracting. A major report, integrating survey and utilization analyses at Fallon, Marshfield, Kaiser, and the Twin Cities (survey only) demonstration sites, will be produced in Fall 1984.

Evaluation of the Medicare Competition Demonstrations

Project No.: 500-83-0047
Period: October 1983 - December 1987
Funding: \$ 3,160,190
Contractor: Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, N.J. 08540
Project Officer: Alan Friedlob
Evaluative Studies Staff

Description: The Health Care Financing Administration is sponsoring an evaluation of a major series of demonstrations, designed to introduce significant competition into the market for providing health services to Medicare beneficiaries. The demonstrations involve over 50 health maintenance organizations and other competitive medical plans (CMP's) throughout the United States that provide health services to Medicare beneficiaries for a prospectively determined payment. This evaluation focuses on the following major policy issues:

- What are the impacts of enrollment of Medicare beneficiaries by CMP's under risk-based capitation on the use, quality, and cost of care?
- What are the determinants of consumer choice of CMP's? What marketing strategies are pursued by CMP's?
- What are the impacts on the fee-for-service sector of risk-based capitation payments to CMP's under Medicare?
- How do CMP's compete with one another and with the fee-for-service sector within the same market area?

Status: The evaluation began in October 1983. Preliminary findings will be available in the project's first annual report in Fall 1984. A summary of the evaluation's objectives and study design is available.

Medicare Beneficiary Decisionmaking About Health Plans

Funding: Northwestern University Policy Center
(See page 131)
Project Allen Dobson
Officer: Office of Research

Description: As part of its overall Policy Center grant to conduct health policy analyses and short-term research, Northwestern University is conducting research into what consumer behavior would be under a voucher system in which Medicare enrollees would choose among competing health plans. Their research examines consumer knowledge about health plans, interest in a voucher system, preferences regarding services covered and prices, and evidence of biased selection of high or low users into certain types of plans.

Status: Results of a survey of Medicare enrollees are being analyzed. An interim final report has been prepared entitled, "Medicare Vouchering."

Medicaid Competition Projects

Santa Barbara Health Initiative

Project No.: 11-P-98036/9-02
Period: September 1981 - December 1984
Funding: \$ 424,364
Grantee: California Department of Health Services
76 Stephanie Drive
Sacramento, Calif. 93901
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This demonstration will support the Santa Barbara Health Initiative (SBHI) in the development and testing of a primary care network to serve all categories of the Medicaid population. The SBHI will be reimbursed at 95 percent of projected fee-for-service expenditures and will assume risk for Medicaid services. The primary care physicians will act as case managers, providing primary care and authorizing referrals when necessary. The SBHI will advance block payments to hospitals as an incentive to participate and be responsible for proper utilization as controlled by the primary care physician. SBHI plans to demonstrate that the Medi-Cal program can be operated more efficiently on a county level, with greater participation of private and public physicians and other providers.

Status: As of September 1, 1983, the health care of the entire Medi-Cal population in Santa Barbara County (approximately 24,500 beneficiaries) became the responsibility of this demonstration project. One of the major tasks completed involved the development of an acceptable operational protocol as required by the Health Care Financing Administration. Other tasks include:

- Negotiating contracts with providers throughout the county, including 8 hospitals, and 432 physicians.
- Securing an exemption from Knox-Keene legislation.
- Selecting Jurgovan and Blair to develop and implement the claims processing and management information system.

Monterey County Health Initiative

Project No.: 11-P-98035/9-02
Period: September 1981 - April 1986
Funding: \$ 369,490
Grantee: California Department of Health Services
76 Stephanie Drive
Sacramento, Calif. 93901
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This project is designed to develop and test a capitated primary care network to serve all categories of the Medicaid population in Monterey County. The Health Initiative is organized as a case-management network focusing on the primary physician. The Monterey County Health Initiative will be reimbursed at 95 percent of the projected expenditures and will assume risk for Medicaid services. Primary physician accounts will be set up to monitor incoming funds and outgoing expenses. Physicians will be at risk for losses or savings that accumulate in the accounts.

Status: The Monterey County Health Initiative became operational on June 1, 1983. It became responsible for the approximately 26,000 Medi-Cal beneficiaries. Significant tasks include:

- Negotiating contracts with providers throughout the county, including 6 hospitals, and 160 primary care physicians.
- Securing an exemption from Knox-Keene legislation.
- Selecting Jurgovan and Blair to develop and implement the claims processing and management information system.

Florida Alternative Health Plan Project

Project No.: 11-P-98231/4-01
Period: June 1982 - June 1986
Funding: \$ 729,114
Grantee: State of Florida
1317 Winewood Boulevard
Tallahassee, Fla. 32301
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: This project is designed to demonstrate and test a number of methods for promoting competition among health care providers and insurers. The competitive models include:

- Competitive alternative health plans (competitive procurement process).
- Recipient case management (case management focused on overutilizers).
- Alternative health plan for the frail elderly (risk contracts with organizations to provide health, home, and community-based services on a prepaid basis).
- Medical care vouchers (consumer choice model utilizing nonnegotiable voucher).

Status: Two health maintenance organizations in Dade county responded, but the State did not proceed through the procurement process because of a protest filed by one bidder. Florida developed the protocol for the competitive alternative health plans module and for recipient case management. Three different organizational models are to be implemented by June 1984 in Jacksonville, Tampa, and Orlando. A request for procurement to all alternative health plans in five counties was released in June 1983. A final protocol for the frail-elderly module and medical care vouchers are to be submitted by June 1984.

Medicaid Voucher Demonstration

Project No.: 11-P-98223/5-02
Period: June 1982 - June 1986
Funding: \$ 556,160
Grantee: Minnesota Department of Public Welfare
2nd Floor-Space Center
444 Lafayette Road
St. Paul, Minn. 55101
Project Officer: G. Theodore Saffran
Division of Health Systems and Special Studies

Description: This project is designed to test a Medicaid capitation demonstration with the following major objectives:

- To further the evolution of a competitive health care system by shifting a publicly supported program (Medicaid) to a prepaid basis.
- To control public expenditures for health care by switching from an open-ended provider/consumer-induced demand system to a budgeted, prepaid reimbursement system.
- To create and test various policies and systems for prepaid Medicaid programs.

Status: The design phase is scheduled to be completed in June 1984, followed by a 2-year implementation. The basic accomplishment thus far in the design phase has been the hiring of the Amherst H. Wilder Foundation to be the principal management consulting firm in designing the demonstration. The design is expected to incorporate a means to convert a substantial portion of the Medicaid population in three counties (to be determined) to a prepaid, prospective risk, capitation reimbursement system. If successful, this demonstration should further intensify provider competition in the chosen counties while arresting the cost spiral in the State program. A draft protocol of the operational aspects of the demonstration is expected during Spring 1984 for Health Care Financing Administration review and comment.

Arizona Health Care Cost-Containment System

Project No.: 11-P-98239/9-01
Period: June 1982 - June 1985
Grantee: Department of Health Services
1200 West Washington, Room 224
Phoenix, Ariz. 85007
Project Officer: Sidney Trieger
Division of Health Systems and Special Studies

Description: This project is designed to test the effectiveness of establishing under the Social Security Act, Title XIX, a Medicaid program based on competitive principles, including primary care physicians acting as gatekeepers, prepaid capitated contracts, competitive bidding, the use of nominal copayments, limited restrictions on freedom of choice, and capitated payment by the Health Care Financing Administration.

Status: Arizona Health Care Cost-Containment System (AHCCCS) was implemented October 1, 1982. Completed milestones include: approval of a Section 1115 waiver application and a State plan; selection of MCAUTO Systems as the contractor responsible for promotion, procurement of contract providers, provider management, public relations, and program operations; development and approval of a capitation rate; and approval of a second-year continuation application. The State awarded contracts to 19 prepaid health plans for the second year of the AHCCCS demonstration. The open enrollment period was held, and the program is now in its second year of operation. The contract by the State with MCAUTO Systems has experienced significant cost overruns.

Evaluation of the Arizona Health Care Cost-Containment System

Project No.: 500-83-0027
Period: June 1983 - September 1986
Funding: \$ 2,489,488
Contractor: SRI International, Inc.
333 Ravenswood Avenue
Menlo Park, Calif. 94025
Project Officer: Richard Yaffe
Evaluative Studies Staff

Description: This project will evaluate the implementation, operation, and impact of the Arizona Health Care Cost-Containment System (AHCCCS), which is a unique and innovative State-sponsored demonstration that provides public assistance medical care (medical assistance) to residents of Arizona who are eligible for Aid to Families with Dependent Children and Supplemental Security Income cash payments. The study will focus on measuring the effects of AHCCCS on cost, quality, and utilization of health care as well as issues related to patient access and satisfaction. The following major innovative cost-containment methods, which are unique to Arizona among all State Medicaid Programs, will be evaluated:

- Capitation prepayment contracts, awarded as a result of competitive bidding, to health care plans that provide or arrange for the provision of covered services.
- "Gatekeeping" by a primary care physician who will be responsible for either providing or authorizing the services to be reimbursed for the enrollees, including any services provided by specialists.
- Use of nominal copayments as a means of inhibiting unnecessary utilization.
- Restriction on freedom-of-choice of plans and providers.
- Capitated payment of Federal financial participation by the Health Care Financing Administration to the State of Arizona based on the number of enrollees.

Status: During the first year of the contract, SRI produced the following documents:

- A literature review on the major study topics and the methodologies of their evaluation.
- A draft evaluation plan that details the issues to be addressed by the study and the methodological approaches to be utilized.
- A draft description of the events that occurred during the first year of the AHCCCS program operation.

Missouri Medicaid Prepaid Health Demonstration Project

Project No.: 11-P-98225/7-02
Period: June 1982 - June 1986
Funding: \$ 393,917
Grantee: Missouri Department of Social Services
P.O. Box 88
Jefferson City, Mo. 65103
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This project will demonstrate and test a city-wide consumer choice model characterized by the use of various incentives, marketing techniques, and the offering of a range of alternative health plans. The project incorporates components of competitive systems including:

- Consumer choice among alternative health plans.
- Risk sharing based on capitated reimbursements.
- A variety of marketing incentives.
- Participation of a range of organizational types.

All participating plans will offer the mandatory minimum benefit package for the categorically needy under the prepaid arrangement.

Status: Missouri has begun operation of the consumer choice model for Medicaid recipients. Missouri will offer enrollment to the Aid to Families with Dependent Children (AFDC) beneficiaries in six alternative health plans in Kansas City. Four of the six health plans participating are newly formed. The plans include two federally qualified, health maintenance organizations, two full-service hospitals, and two neighborhood health centers. Separate physician sponsored programs will be offered as alternatives to the health plans. Enrollment began on January 5, 1984, for newly eligible Medicaid recipients.

Statewide Medicaid Competition Demonstration

Project No.: 11-P-98222/2-02
Period: June 1982 - June 1986
Funding: \$ 792,552
Grantee: New Jersey Department of Human Services
324 East State Street
Trenton, N.J. 08625
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This project will demonstrate and test a competitive model in which Medicaid eligibles may select primary care providers as case managers for 6-month intervals that will be responsible for all direct primary care delivery and referrals for ancillary services for noninstitutional recipients. Case managers will be reimbursed on a capitation principle and will be at risk for selected services. The State will contract with broker organizations selected through a bidding process that will be responsible for:

- Marketing to case managers and eligibles.
- Enrolling case managers and eligibles.
- Quality control monitoring.
- Operation of a grievance procedure system for providers and eligibles.

The Professional Standards Review Organization has been selected as the broker for the first phase.

Status: New Jersey anticipates enrolling 15,000 beneficiaries during the first year of the demonstration. The operational phase commenced in June 1983. Approximately 300 beneficiaries have enrolled during the first phase in three rural counties in northern New Jersey. The second phase, in which the demonstration will be extended to more densely populated, urbanized counties, is scheduled to begin in April 1984. A protocol describing the various operational aspects of the demonstration has been approved by the Health Care Financing Administration.

Monroe County MediCap Plan

Project No.: 11-P-98230/2-02
Period: June 1982 - June 1987
Funding: \$ 700,322
Grantee: New York Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: Monroe County and New York State will participate in a reimbursement demonstration involving a prepaid capitated rate for Medicaid clients involved in the MediCap plan. Participating clients will be offered several delivery alternatives including existing health maintenance organizations, existing clinics or outpatient departments, or a new alternative health plan. A capitated rate, equal to or less than 95 percent of fee-for-service, will be agreed on between the State and County. The County will, in turn, develop rates for categories of eligibles with possible adjustments for types of delivery systems.

Status: This project is in its developmental phase. A final protocol is scheduled to be submitted by Spring 1984, with enrollment to begin October 1984. An extensive data base is being developed to construct the Medicaid capitated rate.

Competitive Managed Health Plans for AFDC Medicaid Recipients

Project No.: 11-P-98330/1-01
Period: March 1983 - March 1986
Grantee: Massachusetts Department of Public Welfare
600 Washington Street
Boston, Mass. 02111
Project Officer: Sherrie Fried
Division of Health Systems and Special Studies

Description: This project is designed to demonstrate and evaluate three models of "managed health care," developed by the Massachusetts Medicaid program for recipients of Aid to Families with Dependent Children (AFDC), in terms of cost, utilization, consumer satisfaction, administration, and quality of care. The three models are: case management, health maintenance organizations, and ambulatory capitation.

Status: This project is in its developmental phase. The State is currently working on the development of the ambulatory capitation model.

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Evaluation of the Medicaid Competition Demonstrations

Project No.: 500-83-0050
Period: September 1983 - September 1987
Funding: \$ 3,098,938
Contractor: Research Triangle Institute
P.O. Box 12194
Research Triangle Park, N.C. 27709
Project Officer: Spike Duzor
Evaluative Studies Staff

Description: The Medicaid demonstrations are being implemented in six States (California, Florida, Minnesota, Missouri, New Jersey, and New York), to enhance the role of competition in the delivery of publicly-financed Medicaid services. The evaluation is designed to describe and analyze the separate demonstrations, as well as to conduct a comparative impact analysis across the projects. A series of case studies and analytical reports will be done, highlighting the impact of the demonstrations' cost-containment modalities and their subsequent effect on quality of care, patient utilization, and patient satisfaction.

Status: The evaluation is conducting initial site visits to the six participating States. Detailed case studies highlighting the status of each demonstration will be available in May 1984. A finalized research design, data collection plan, and primary data collection instruments will be completed by July 1984.

Health Maintenance Organization Studies

Physicians' Use of Medical Care Resources in a Prepaid Group Practice, Health Maintenance Organization

Project No.: 18-P-97993/9-02
Period: August 1981 - August 1983
Funding: \$ 343,814
Grantee: Kaiser Foundation Research Institute
1956 Webster Street, Room 310-B
Oakland, Calif. 94612
Project Officer: William Sobaski
Office of Research

Description: This research project will measure the intensity of resource use (radiology, laboratory, drugs, outpatient procedures, and hospitalizations) by physicians in a prepaid group practice, health maintenance organization, and will determine factors related to differences among physicians in the intensity of resource use. The findings will help to explain differences among physicians in patient-care patterns that affect costs of care and treatment.

Status: All data analyses are completed. A draft final report was prepared, and is being revised.

Health Status Measure for Adjusting Health Maintenance Organization Rates of Medicare Beneficiaries

Project No.: 18-P-98179/5
Period: March 1982 - March 1984
Funding: \$ 213,219
Grantee: University of Michigan
School of Public Health
109 Observatory Street
Ann Arbor, Mich. 48109
Project Officer: Marian Gornick
Division of Beneficiary Studies

Description: This study will investigate the use of a health status measure to improve the current method for reimbursing health maintenance organizations for Medicare beneficiaries under the at-risk alternative in Section 1876 of the Social Security Act. The project will also explore the ability of simple measures of perceived health status obtained through telephone and mail surveys to predict future utilization and costs for a Medicare population.

Status: Field work has been completed on the survey and a response rate of 80 percent was attained. Data from Blue Cross/Blue Shield of Michigan, Michigan Medicaid, and the Medicare Statistical System (Health Care Financing Administration) are being obtained and compared with the survey data.

Adjusted Average Per Capita Cost

Funding: Brandeis University Health Policy Consortium
(See page 132)
Project: James Lubitz
Officer: Division of Beneficiary Studies

Description: The University Health Policy Consortium, as part of its grant, is studying ways to improve the current adjusted average per capita cost (AAPCC). The work has been focused on three areas:

- The use of prior utilization to predict future utilization.
- The use of indicators of disability in the AAPCC.
- An examination of selected methodological aspects of the AAPCC.

Status: Prior utilization--Results indicate that prior utilization is a significant predictor of future utilization. The predictive power is improved when prior hospital stays are classified into those for self-limiting conditions and those for conditions, like cancer, indicative of chronic, recurring problems. Work is continuing to refine an AAPCC model incorporating diagnostic information on prior hospital stays. Preliminary results are contained in "Prediction of Subsequent Year Reimbursement Using the Medicare History File" by Jennifer Anderson and Abby Resnick, University Health Policy Consortium, Discussion Paper, May 1982.

Disability level--Results indicate that disability level is a significant predictor of health care use. A disability level factor, therefore, would theoretically improve the current AAPCC. However, any improvement would have to be weighed against the cost and administrative burden of acquiring disability data on Medicare enrollees. A discussion of a possible disability adjustment is contained in two draft papers from the Health Policy Consortium by Leonard Gruenberg and Neil Stuart, "A Health Status-Based AAPCC: The Disability Level Based Approach," and "The Use of Disability Status as a Health Status Measure for Updating a Prior Utilization Reimbursement Model."

Methodological aspects--The University Health Policy Consortium has been examining a number of methodological aspects of the AAPCC. They include:

- An examination of the statistical assumptions implicit in the AAPCC.
- A synthetic estimator approach to developing a denominator for the institutional factor of the AAPCC.
- Accounting for geographic variations in the AAPCC.
- Analysis of risk sharing and reinsurance for Medicare health maintenance organizations (HMO's).
- Monitoring of HMO enrollment practices by analysis of mortality rates.

Reports on these topics should be available in Spring 1984.

Research to Improve the Adjusted Average Per Capita Cost Formula to Pay Health Maintenance Organizations

Funding: Intramural
Project James Lubitz
Director: Division of Beneficiary Studies

Description: Medicare payment to at-risk health maintenance organizations (HMO's) is based on the adjusted average per capita cost (AAPCC) formula, which uses the enrollee's age, sex, welfare status, and institutional status as underwriting factors. Recent studies in the Office of Research and Demonstrations, Health Care Financing Administration, have shown that the AAPCC may not adequately adjust for biased selection of lower than average users of health services into HMO's. There has also been concern with a number of technical aspects of the AAPCC. The passage of the Tax Equity and Fiscal Responsibility Act in 1982 gave added importance to the AAPCC formula, because the new law is expected to greatly increase the number of at-risk HMO's in Medicare. The AAPCC studies examine both ways to improve the current AAPCC and the effect of adding additional underwriting factors to the formula.

Status: Current projects are investigating the use of underwriting factors based on prior use of health services, prior entitlement to Social Security disability benefits, prior entitlement to Supplemental Security Income benefits, and early retirement. The following working papers have been produced:

- "An Examination of the Geographic Factor Used in the AAPCC."
- "Two Studies in the Evaluation of the AAPCC: A Study of the Sensitivity of the AAPCC to the Institutional Underwriting Factors, and Predicting Reimbursement with the AAPCC Underwriting Factors."

Former Disability as an Adjustment Factor for the Adjusted Average Per Capita Cost

Funding: Intramural
Project Jerry Riley
Director: Division of Beneficiary Studies

Description: Medicare data show that approximately 8 percent of Medicare beneficiaries 65-69 years of age were formerly entitled to Medicare because of disability. These beneficiaries tend to incur nearly twice as much reimbursement as other beneficiaries their age. Consequently, the Office of Research will develop and test an additional factor for the adjusted average per capita cost (AAPCC) that will adjust for previous receipt of Social Security disability benefits among aged enrollees. Included in the study will be beneficiaries who were formerly entitled to disability benefits under Social Security, but were never Medicare entitled.

Status: The Social Security Administration has provided information on former receipt of disability benefits for a sample of Medicare beneficiaries. This information was recently linked to data from the Medicare Continuous History File. The study will also look at factors on early retirement and receipt of Supplemental Security Income benefits for possible inclusion in the AAPCC. It is anticipated that results of the study will be available in mid-1984.

Use of Prior Utilization for Prospective Payment of Health Maintenance Organizations

Funding: Intramural
Project James Beebe
Director: Division of Beneficiary Studies

Description: The Tax Equity and Fiscal Responsibility Act of 1982 permits health maintenance organizations (HMO's) to receive prospective payments for their enrollees. The amount of payment is to be determined by the characteristics of the HMO's enrollees. The current adjusted average per capita cost relies on demographic characteristics of the HMO enrollees. There is considerable evidence that, even when controlling for demographic variables, HMO enrollees tend to be healthier than the general Medicare population. This research investigates the feasibility of using prior utilization along with demographic characteristics to control for this bias and more accurately predict future medical costs. The utilization variables being investigated (prior hospital days and whether or not the Part B, Supplementary Medical Insurance, deductible was met) were chosen because they are readily available from the Medicare administrative data system.

Status: The study found that for groups of persons with high or low levels of prior utilization, the models which include prior use variables predict reimbursement better than models containing only demographic variables. However, there is still room for improvement. Future work will concentrate on models that incorporate diagnosis for prior hospital stays. A working paper entitled, "Executive Summary: Using Prior Utilization Information to Determine Payments for Medicare Enrollees in HMO's" has been produced. A full report should be available in Spring 1984.

Medicare Health Maintenance Organization Additional Benefits

Funding: Intramural
Project Marni Hall
Director: Division of Economic Analysis

Description: Section 114 of Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), requires that, to the extent a health maintenance organization's (HMO) Medicare payment exceeds its adjusted community rate under a risk-sharing contract, the HMO must use the savings to provide its Medicare members additional benefits or reduced cost sharing. Section 114 also requires that the Secretary of the Department of Health and Human Services conduct a study of the additional benefits provided under this provision. This study will report on the number of HMO's subject to the additional benefits requirement, and the nature of the benefits that HMO's choose to provide.

Status: The study depends on data that will be collected in 1984. This information will be compiled in a report due to Congress in late 1985.

Other Alternative Payment Systems

Massachusetts Dental Case Management

Project No.: 11-P-97388/1-04
Period: February 1980 - January 1984
Grantee: Massachusetts Department of Public Welfare
80 Boylston Street, #315
Boston, Mass. 02116
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: The overall goal of this study is to demonstrate that capitated dentistry can result in a cost-effective and improved method of delivering dental care to a Medicaid population. The specific objectives are:

- To demonstrate the effects of case management and capitation on the cost and quality of dental care.
- To evaluate an alternative reimbursement method of providing dental services.

Guaranteed eligibility, capitation, and lock-in to provider (beneficiary restricted to one provider) are three concepts being tested in this demonstration.

Status: The capitated dental coverage for Medicaid beneficiaries has been implemented for 3½ years. The project reached 75 percent of its overall enrollment goals. About 2,000 Aid to Families with Dependent Children recipients (670 families) have been enrolled in the experimental group. A total of only 30 people have disenrolled since the project began, mainly because they moved out of the service area. Dentists are reimbursed \$4.20 per enrolled person per month, a figure that is based upon Schoen's "chair hour" formula. The formula multiplies the estimated amount of dentist and hygienist chair time by the respective costs of that time, all multiplied by estimated overall service utilization. Fourth year tasks are to complete the 2-year demonstration phase and to evaluate the demonstration. The State of Massachusetts is considering whether or not to continue the dental capitation under Medicaid at the conclusion of the demonstration period.

PROGRAM ANALYSIS AND EVALUATION

National Medical Care Utilization and Expenditure Survey

Analysis of NMCUES Data

Project No.: 500-81-0047
Period: September 1981 - April 1984
Funding: \$ 3,487,763
Contractor: Research Triangle Park Institute
P.O. Box 12194
Research Triangle Park, N.C. 27709
Project Officer: Herbert Silverman
Division of Program Studies

Description: This project involves the analysis of data (tabulations, models, and data file production) and the publication of series reports on the National Medical Care Utilization and Expenditure Survey (NMCUES). This survey was co-sponsored by the Office of Research and Demonstrations, Health Care Financing Administration, and the National Center for Health Statistics, Public Health Service. NMCUES was used to collect detailed sociodemographic, health status, health insurance, and health care payment data that were not available from either the Medicare or Medicaid administrative record systems. Data were obtained from three survey components:

- A randomly selected national household sample (HHS) of the civilian noninstitutionalized population.
- Randomly selected State Medicaid household samples (SMHS) of the civilian noninstitutionalized Medicaid population in four States: California, Michigan, Texas, and New York.
- A Medicare and Medicaid administrative records survey (ARS) linked to HHS and SMHS Medicare and Medicaid respondents.

The data collected will allow for analysis of policy issues that include the New Federalism, Medigap, out-of-pocket costs, and benefit package changes.

Status: The contract is now in its report production phase. In addition to answering numerous data requests, 16 reports are in various stages of development. Three have been published. These reports will emphasize the relationship of utilization to health insurance coverage, out-of-pocket expenditures, access to health care, and Medicaid use by social and ethnic groups.

Perspectives on Health Care from National Medical Care Utilization and Expenditure Survey: United States, 1980

Funding: Intramural
Project: Judith A. Kasper
Officer: Division of Beneficiary Studies

Description: The purpose of this project is to develop an overview report of major findings from the National Medical Care Utilization and Expenditure Survey. Data for the Nation and the Medicare and Medicaid populations will be presented, covering sociodemographic characteristics, access to primary care, and use and expenditures for all types of health services. Special studies will include use and expenditures by the "crossover" population (persons covered by both Medicare and Medicaid), and levels of Medicaid use and expenditures taken from a four-State sample of Medicaid claims data.

Status: Completion of a draft report is expected early in 1985.

Title XIX Data Development

Acquisition and Analysis of State Medicaid Data (Tape-to-Tape)

Project No.: 500-81-0030
Period: June 1981 - April 1985
Funding: \$ 1,740,366
Contractor: SysMetrics, Inc.
4520 East-West Highway
Suite 600
Bethesda, Md. 20814
Project: David K. Baugh
Officer: Division of Program Studies

Description: This project is acquiring person-level data on Medicaid enrollment, claims, and providers from State Medicaid Management Information Systems (MMIS). Uniform files are being created to compare State trends. Data collection includes five States for 1980, 1981, and 1982. These person-level data are a key element to improving the Health Care Financing Administration's ability to conduct program evaluation, strengthen program management, evaluate policy alternatives, and assist States in the area of Medicaid financing.

Status: Through December 1983, person-level enrollment, claims, and provider files were obtained from State MMIS. System documentation was reviewed and code maps were produced to translate raw data into "uniform" files. Initial data processing and "early return" tabulations were completed for 1980 and 1981 data from Michigan and New York. Two presentations were made to the 1983 American Public Health Association Annual Meeting, one on providers and the other on a comparison of use and expenditures for Medicaid in two States.

Who's on Medicaid: A Comparison of Available Data

Funding: Intramural
Project: Gerald S. Adler
Director: Division of Beneficiary Studies

Description: Data on Medicaid are collected from different sources for different purposes, with information on basic program parameters varying substantially. This project compares basic program statistics, such as people enrolled and served, units of services, and expenditures, from a number of sources. Data are examined from: routine administrative reports and program statistics submitted by the States to the Federal Government; a special study using Medicaid claims processing files; on-going surveys such as the Current Population Survey and the National Health Interview Survey; and one-time surveys such as the 1977 National Medical Care Expenditure Survey and the 1980 National Medical Care Utilization and Expenditure Survey. Emphasis in the analysis is on the reasons for differences.

Status: Completed. A paper was presented at the annual meeting of the American Statistical Association in August 1983 entitled, "Who's On Medicaid: A Comparison of Available Data."

Medicare Fixed-Price Contracting

Evaluation of Part B Fixed-Price Medicare Contracts

Project No.: 500-81-0041
Period: September 1981 - December 1983
Funding: \$ 514,603
Contractor: Abt Associates, Inc.
55 Wheeler Street
Cambridge, Mass. 02138
Project: Joel Broida
Officer: Division of Economic Analysis

Description: This project evaluated the Medicare Part B fixed-price carrier experiments in Maine, Illinois, and upstate New York. The evaluation examined the experiments' effects on program costs and quality of carrier performance. Fixed-price arrangements were compared with the previous systems in the three areas. The performance of each experimental contractor was also compared with the performance of two comparable cost-reimbursed contractors.

Status: Findings indicate that the fixed-price contractor experiments resulted in reduced Federal costs for carrier services. The decreased costs were achieved by using different processing sites and better processing systems, and through some economics of scale. With the exception of two areas where startup problems occurred because of the consolidation of processing territories, no adverse impact of the experiments on beneficiaries or providers was found.

Study of the Quality and Effectiveness of Experimental Fixed-Price Medicare Part A
Intermediary Contracting

Project No.: 500-83-0030
Period: June 1983 - December 1984
Funding: \$ 203,595
Contractor: Abt Associates
55 Wheeler Street
Cambridge, Mass. 02138
Project William J. Sobaski
Officer: Division of Reimbursement Studies

Description: This project will examine the impact of experimental fixed-price contracting for intermediary services in two States, New York and Missouri. The contractor will assess the procurement processes, the transition periods, and the resultant states of readiness for operations. Analyses will be made of claims processing and program outlays, provider and beneficiary services, and the quality of audit and settlement services in the initial year of operations on a fixed-price basis. Recommendations will be provided for a methodology suitable for use in evaluating other fixed-price contracting arrangements.

Status: This project was initiated June 27, 1983. Site visits began in September 1983. Initial descriptive and analytic reports flow began in December 1983 and continue on a bimonthly basis. The final research design report has been received and accepted.

Program Management

Methodology for Performing Computer-Assisted Simulations of the Effects of Changes in Medical Procedural Terminology Systems

Project No.: 500-78-0013
Period: June 1978 - April 1984
Funding: \$ 1,047,631
Contractor: Moshman Associates
5400 Goldsboro Road
Bethesda, Md. 20817
Project Officer: William Sobaski
Division of Reimbursement Studies

Description: This project studies physician response to reimbursement alternatives including analysis of price trends, relative values, and relations between medicine and private health insurance. An objective of the project is to develop and demonstrate a methodology for simulating the effects of changes in medical procedural terminology and coding systems on program outlays, statistics, information systems, and reimbursement levels.

Status: The project to date has:

- Developed California Relative Value Studies, National Association of Blue Shield Plans, and Current Procedural Terminology (CPT) crossovers to the Health Care Financing Administration Common Procedural Coding System (HCPCS).
- Developed Current Procedural Terminology-4, 3rd Revision to International Classification of Diseases, 9th Revision, Clinical Modification, Volume 3 crossovers.
- Developed a computerized monitoring system and discussed it at a conference of 200 carriers, State, and Health Care Financing Administration representatives.
- Assessed first 2 years of HCPCS usage in South Carolina.
- Assessed first 11 months of HCPCS usage in Washington and Indiana.

Proposal for the Development of a Medicaid Fraud and Abuse Detection Methodology

Project No.: 11-P-97617/5-02
Period: March 1980 - March 1983
Funding: \$ 57,832
Grantee: Illinois Department of Public Aid
624 S. Michigan
Chicago, Ill. 60605
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: This 3-year project will develop and field test an empirically-based fraud and abuse detection methodology for the Illinois Medicaid Program to increase the State's review and monitoring capabilities. The basic assumption is the belief that various types of fraud and abuse practiced by Title XIX providers represent conscious decisions regarding trade-offs between:

- Exposure to risk and desired per-unit profit.
- Desired level of effort.
- How those factors relate to a target level of profit associated with practice size.

Status: The grantee examined the data available on providers who were audited between 1973 and 1979. Profiles were developed as a result of the data analysis. A final report was submitted in January 1984.

State Medicaid Information Center Project

Project No.: 18-P-97923/3-03
Period: January 1981 - January 1985
Funding: \$ 719,018
Grantee: National Governors' Association
Center for Policy Research
Hall of the States
Washington, D.C. 20001
Project Officer: Aileen Pagan-Berlucchi
Division of Program Studies

Description: This grant project monitors changes in State Medicaid program policy and disseminates information on these changes through a survey-based report updated every 6 months. The National Governors' Association (NGA) also contracts with research groups outside the Federal Government to produce research reports on special topics of current interest in the area. The project group at NGA works closely with State Medicaid directors and other program personnel in developing research topics and data collection priorities.

Status: Key products from this project include:

- Medicaid Survey Report: "Recent and Proposed Changes in State Medicaid Programs" from 1982 on, co-published with the Intergovernmental Health Policy Project.
- "Primary Care Network and Medicaid" - A background paper, December 1981.
- "Medicaid: Freedom of Choice" - A review of waiver applications submitted under Section 2175 of the Omnibus Budget Reconciliation Act of 1981, August 1982.
- "Volume Purchasing of Goods and Services in State Medicaid Programs," October 1982.
- "Medicaid Program Changes, State-by-State Profiles," May 1982.
- "Controlling Medicaid Costs: Second Surgical Opinion Programs," November 1982.
- "Catalog of State Medicaid Program Changes - The State Medicaid Program Information Center," December 1982.
- "Reducing Excessive Utilization of Medicaid Services: Recipient Lock-in Programs," June 1983.
- "Nursing Homes, Hospitals, and Medicaid: Reimbursement Policy Adjustments, 1981-1982," March 1983.

State Legislative Resource and Information Center on Health Care Financing

Project No.: 19-P-98266/8-01
Period: June 1983 - May 1986
Funding: \$ 547,017
Grantee: National Conference of State Legislatures
1125 Seventeenth Street, Suite 1500
Denver, Colo. 80202
Project Officer: Vic McVicker
Division of Hospital Experimentation

Description: This project will demonstrate that a centralized source of information on State and Federal health care financing initiatives and programs will assist the Nation's State legislatures, as well as the Health Care Financing Administration, by contributing to a more informed decisionmaking process. A number of mechanisms will be used to establish and disseminate information from the resource center. These include surveys of State legislatures, publications, seminars, direct technical assistance, and response to requests for specific information.

Status: During the first 6 months, the National Conference of State Legislatures (NCSL):

- Sponsored a national conference for State officials on changing health policy.
- Held several sessions on health care cost-containment issues at the NCSL Annual Meeting.
- Published a directory of legislative health staff.
- Wrote an article on growing State interest in hospital rate-setting commissions.
- Mailed out their 1984 legislative health issues survey, and responded to more than 200 information requests from State legislatures.

Intergovernmental Health Policy Project

Project No.: 18-P-98148/3-02
Period: March 1982 - February 1985
Funding: \$ 885,000
Grantee: George Washington University
Rice Hall, 6th Floor
Washington, D.C. 20052
Project Officer: Aileen Pagan-Berlucchi
Division of Program Studies

Description: This grant project describes current health law, policy, and legislative actions affecting State Medicaid programs. The Intergovernmental Health Policy Project (IHPP) compiles and disseminates information on State health activities, including new developments in the Medicaid cost-containment area. IHPP serves as a clearinghouse on State legislative actions. Through this clearinghouse function, IHPP distributes a monthly newsletter, "State Health Notes," detailing the current status and pending changes in the medical program. IHPP also disseminates special summaries of topical issues in the Medicaid program through the "Legislative Snapshot" report series and periodic background reports.

Status: Key products from this project include:

- Medicaid Survey Report: "Recent and Proposed Changes in State Medicaid Programs" from 1982 on, co-published with the National Governors' Association.
- "State Health Notes," a newsletter published 10 times each year.
- Background reports (for example, "Medigap: Issues and Update, 1982," "Alternatives to Institutional Care for the Elderly: An Analysis of State Initiatives," September 1981, and "Creating the Medical Marketplace: Selective Contracting in California's Medi-Cal Program (1983)."
- "Legislative Snapshot" (on such topics as nursing homes and Medicaid).
- "State Mental Health Notes," a newsletter published 10 times each year.

Analyze and Make Recommendations on Information and Assistance Needs and Resources from the Perspective of the Medicaid Agencies

Project No.: 18-P-98220/3-01
Period: June 1983 - April 1984
Funding: \$ 92,633
Grantee: American Public Welfare Association
1125 Fifteenth Street, Suite 300
Washington, D.C. 20005
Project Officer: Paul W. Eggers
Division of Beneficiary Studies

Description: This project was designed to assess the information and assistance needs of State Medicaid agencies through a survey of State Medicaid directors and a review of national information and assistance activities. The project's three distinct but interrelated objectives are:

- To analyze and prioritize the information and assistance needs of State Medicaid directors.
- To analyze the information and assistance resources available to State Medicaid directors.
- To make specific recommendations as to how the information and assistance resources could be augmented, altered, and better utilized to meet the needs of State Medicaid directors.

Status: A survey of State Medicaid directors has been completed and the data have been compiled and analyzed. Relevant Health Care Financing Administration personnel have been interviewed as well. A draft final report has been written and is under review.

Policy Centers

Program in Health Care Policy and Financing at Northwestern University

Project No.: 18-P-97265/5-04
Period: September 1978 - March 1983
Funding: \$ 2,334,008
Grantee: Northwestern University
629 Noyes Street
Evanston, Ill. 60201
Project Officer: Allen Dobson
Office of Research

Description: The Center for Health Services and Policy Research of Northwestern University assists the Health Care Financing Administration (HCFA) in evaluating and conducting health policy analyses and short-term research projects in priority areas affecting programs that are administered by HCFA. Each year, under the 5-year grant, the Center and HCFA develop an agenda of specific topics and projects to conduct. The Center then submits the research and policy papers to HCFA as the studies are completed. They also publish their findings in professional journals.

Status: This policy center is in its fifth and final year of operation. Six studies are being conducted:

- Routine Care of the Foot: Implications of Medicare Exclusion.
- Freestanding Ambulatory Health Centers.
- Cost-Effectiveness of Preventive Health Care for HCFA Beneficiaries.
- Medicare Beneficiary Decisionmaking About Health Plans.
- Lessons from the Experience of State Catastrophic Health Insurance Programs.
- Trends in Medicaid Program Expenditures and Changes in Medicaid Program Characteristics.

Final reports on these projects are expected during 1984.

Health Care Financing and Regulation Center at Brandeis University Health Policy Consortium

Project No.: 18-P-97038/1-05
Period: May 1978 - March 1984
Funding: \$ 4,157,586
Grantee: Brandeis University
Florence Heller Graduate School
South Street
Waltham, Mass. 02154
Project Officer: Allen Dobson
Office of Research

Description: The University Health Policy Consortium assists the Health Care Financing Administration (HCFA) in evaluating and conducting health policy analyses and short-term research projects, concentrating in the areas of long-term care, health care quality and effectiveness, and regulation and reimbursement. Each year under the 5-year grant, the Consortium and HCFA develop an agenda of specific topics and projects to conduct. The Consortium then submits the research and policy papers to HCFA as the studies are completed. They also publish their findings in professional journals.

Status: This policy center is in its fifth and final year of operation. There are 12 current projects underway. Of these, five projects were continued from the fourth year of funding:

- Kidney Procurement in the United States.
- Case-Mix Differences Between End-Stage Renal Disease Facilities.
- Home Health Cost Functions.
- Urban Hospital Closing: Qualitative Analysis.
- Mandatory Home Health Studies.

Four projects were related to efforts to improve program efficiency:

- Effect of Medicare Policy on Clinical Policy and Utilization.
- Medicare Cost Control through Claims Analysis.
- Pediatric Appropriateness Evaluation Protocol Instrument.
- Technology Assessment for Insurance Coverage Decisions.

Three projects were related to issues in competition:

- Adjusted Average Per Capita Costs.
- Vertical Integration of Hospitals and Long-Term Care.
- Competition in Home Health.

One project is related to the issues associated with the New Federalism for Medicaid. In addition, a special report, "Alternative Methods of Reimbursement for Home Health Services under Federal Programs" was prepared to provide a resource document for the preparation of a Report to Congress. The report was mandated by the Orphan Drug Act (Public Law 97-414). The Act requires the Secretary of the Department of Health and Human Services to compile and analyze the results of significant studies relating to current and alternative methods of reimbursing for home health services and to make recommendations on methods that might be adapted to federally funded health care programs.

A 6-month extension of the final year is funding three projects:

- Conference on the Future Financing of Long-Term Care.
- Nationwide Test of a Health Status Adjusted Average Per Capita Costs.
- Background Papers on Prospective Payment System Issues.

Program Analysis

Medicaid Programmatic Characteristics Research Study

Project No.: 500-81-0040
Period: September 1981 - September 1983
Funding: \$ 472,320
Contractor: La Jolla Management Corp.
11426 Rockville Pike
Rockville, Md. 20852
Project Officer: Donald N. Muse
Division of Medicaid Cost Estimates
Bureau of Data Management and Strategy

Description: This study designed and implemented a data system that unified selected State Medicaid program characteristics, such as eligibility requirements, service limitations, routine statistical report data, and administrative details, in a single source. This data base will be updated annually for the Health Care Financing Administration (HCFA).

Status: The study has produced, on schedule, a final report detailing the characteristics data. A tape containing the 1982-83 data has also been delivered to HCFA.

Medicaid Cost Containment and Urban Medical Care

Project No.: 18-P-97728/3-02
Period: June 1980 - June 1983
Funding: \$ 704,737
Grantee: The Urban Institute
2100 M Street
Washington, D.C. 20037
Project Officer: Paul Eggers
Division of Beneficiary Studies

Description: The primary objective of this study is to analyze the impact of changes in Medicaid policies on local governments' spending for medical care and hospitals' financial status. The impact on local governments' spending is based on time-series, cross-section data for 22 large cities (in 15 States) during an 11-year period, 1968-1978. Histories of each jurisdiction's Medicaid policies and policy changes are being compiled.

Status: A number of reports have been generated as a result of this study and are available as working papers from the Urban Institute:

- "Cutbacks, Recession, and Care to the Poor: Will the Urban Poor Get Hospital Care?" May 1983.
- "Toward Understanding the Financially Distressed Hospital Problem," June 1982.
- "Care for the Poor and Hospitals' Financial Status: Results of a 1980 Survey of Hospitals in Large Cities," January 1983.
- "Hospitals' Financial Status and Care to the Poor in 1980," August 1983.
- Poor People and Poor Hospitals: Implications for Public Policy," October 1983.

Trends in Medicaid Program Expenditures and Changes in Medicaid Program Characteristics

Funding: Northwestern University Policy Center
(See page 131)
Project Officer: Paul W. Eggers
Division of Beneficiary Studies

Description: This project examines Medicaid program data for 1973-82 to determine the State variations that have occurred in program expenditures. Analyses examine expenditures by type of service and by eligibility group. Changes in expenditures are compared with changes in program administration and coverage to determine the effect that State policies have had on the Medicaid program.

Status: The project was begun March 1983. A draft final report was received March 1984 and is being reviewed.

Health Services Utilization Study

Project No.: 18-P-98442/9-01
Period: September 1983 - September 1986
Funding: \$ 616,268
Grantee: The Rand Corporation
1700 Main Street
Santa Monica, Calif. 90406
Project Officer: James Lubitz
Division of Beneficiary Studies

Description: The purpose of this study is to examine whether high use rates of certain procedures in selected geographic areas reflect inappropriate overuse, and, to a lesser extent, whether low procedure rates in other areas reflect underuse. Three or four procedures that show large geographic variation, consume a significant amount of resources, and are likely to be overused, will be selected for study from six candidate procedures. Medicare Part B claims data from 12 areas in 8 States will be used to study geographic variation. Three areas, a high, medium, and low rate area will be selected from the 12 areas for the chosen procedures. The records of 100 physicians for each procedure in each area will be studied to determine the indications for performing each procedure. Then the indications for each procedure, as abstracted from the medical records, will be compared with the indications drawn up by an expert panel of physicians. The hypothesis is that the indications in the high rate areas will be less generally accepted--suggesting inappropriate overuse.

Status: Work on this study has already begun under funding from three private foundations. Medicare Part B data have been gathered and are being analyzed. Literature reviews on the indications for three procedures have been completed. Procedures likely to be chosen for study include coronary angiography, diagnostic upper gastrointestinal endoscopy, and carotid endarterectomy, with work on data gathering on indications for coronary angiography likely to begin soon. The expert panel of physicians who will rank indications for coronary angiography met in February 1984.

Use of Medicare Services by Disabled Enrollees Under 65 Years of Age

Funding: Intramural
Project James Lubitz and Penny Pine
Directors: Division of Beneficiary Studies

Description: More research has been devoted to the Medicare aged population than to the population of disabled enrollees under 65 years of age. Yet disabled enrollees comprise about 10 percent of Medicare enrollment, and Medicare expenditures for them have been rising faster than for aged enrollees. To increase available knowledge of the Medicare disabled population, analyses are being carried out on patterns of health services used by the disabled. In particular, this population is being analyzed by type of disability award, i.e., disabled worker, adult disabled in childhood (ADC), or disabled spouse. Also, the aged (over 65 years of age) Medicare population who were formerly disabled Medicare beneficiaries are being studied.

Status: Results indicate that per capita reimbursement for the disabled are equal to that of the aged and that disabled women exceed men in per capita reimbursement. The majority (82 percent) of the Medicare disabled population are disabled workers, 14 percent are adults disabled in childhood (ADC), and 4 percent are disabled spouses. Per capita reimbursement in 1978 for ADC's was considerably lower (\$345) than for disabled workers (\$924) or disabled spouses (\$1,051). Aged Medicare beneficiaries who were formerly disabled Medicare beneficiaries have 1.9 times the per capita reimbursement of other Medicare beneficiaries in the same age group. A second study is being planned linking the Social Security Administration's Disability History File to Medicare records. When the link is completed, analyses will examine the relationship of such factors as reason for disability, length of time disabled, and return to work to health care use.

Use of Services by the Dually Entitled

Funding: Intramural
Project: Alma McMillan
Director: Division of Beneficiary Studies

Description: More than 13 percent of the aged population are covered by both Medicare and Medicaid. In view of the proposed and recently enacted changes in both programs, the health care use of the dually entitled is of special interest.

Status: A recently completed study of Medicare use by the dually entitled, published in the Summer 1983 issue of the Health Care Financing Review, found that per capita Medicare reimbursement for the dually entitled was 50 percent higher than for other enrollees and that the mortality rate was also 50 percent higher for the dually entitled. A second study on the aged dually entitled used the National Medical Care Utilization and Expenditure Survey to examine the utilization of noninstitutionalized persons and their reimbursements made by Medicare, Medicaid, and other sources, and the relation of health status, education, and income to health service use. This study corroborated many of the findings of the earlier study, such as higher per capita costs and higher mortality for the dually entitled, even though the institutionalized were excluded. A major finding from this study related to the health status of the elderly poor. The noninstitutionalized aged population covered by Medicare and Medicaid is in substantially poorer health than other noninstitutionalized aged persons covered only by Medicare. A working paper on this study is available. A third study on the dually entitled is planned using person-level data from Medicare and Medicaid in selected States. It will focus on patterns of long-term care and hospital use by the dually entitled. Plans for linking Medicare and Medicaid data for dually entitled individuals are proceeding.

Impact of Deductibles and Coinsurance on Medicare Enrollees

Funding: Intramural
Project: Marian Gornick
Officer: Division of Beneficiary Studies

Description: More than half of Medicare enrollees purchase private supplemental policies ("Medigap") to protect against the costs of Medicare deductibles and coinsurance. This study examines the distribution of liabilities for Medicare cost-sharing and offers proposals for restructuring Medicare coverage to both reduce the need to purchase Medigap coverage and to better protect against catastrophic cost-sharing liabilities.

Status: A report of this study was published in the Fall 1983 issue of the Health Care Financing Review. The study found that in 1980, 25 percent of Medicare enrollees had Medicare cost-sharing liabilities of \$200 or more. The cost of protecting enrollees against liabilities in excess of \$200 would have been \$86 per enrollee in 1980. A model was developed to estimate the additional cost in 1984 of fixing liability at selected limits. The added cost of the protection would be offset by reduced need to purchase "Medigap" policies. Alternatively, Medigap policies offering such catastrophic protection could be offered at lower premiums than present policies offering first-dollar insurance against coinsurance and deductibles.

Studies of Medicare Use Before Death

Funding: Intramural
Project James Lubitz
Officer: Division of Beneficiary Studies

Description: These studies examine the use of Medicare services in the last years of life. This information is needed because of the large percentage of Medicare expenditures for enrollees in their last year and because of the interest in hospice care as an alternative kind of care for the terminally ill.

Status: Studies have shown that 28 percent of Medicare expenditures are for persons in their last year, that persons who die receive more than six times the reimbursements of other enrollees, and that expenditures in the last year are concentrated in the last few months. The studies also show that the relative share of Medicare expenditures going to enrollees in their last year has changed little from 1967 to 1979. The results of these studies were published in Health, United States, 1983, the annual report from the Secretary of the Department of Health and Human Services to the President and Congress, and in the Spring 1984 issue of the Health Care Financing Review. Knowledge gained in these studies is being applied in the administration and evaluation of the hospice benefit. In addition, data on Medicare reimbursements for the dying in conventional settings will be used as comparison data to evaluate the cost and utilization experience under the new hospice benefit. Finally, to expand the range of uses of data on use of Medicare benefits before death, a contract was awarded to obtain permission from States to access their death certificate information at the National Center for Health Statistics. The contract is completed, and studies are beginning to analyze the relation between cause of death and Medicare use.

Post-Surgical Mortality Among the Aged for Common Operations

Funding: Intramural
Project Jerry Riley
Officer: Division of Beneficiary Studies

Description: About 2.5 million hospital stays for surgery for Medicare enrollees occur annually. Much of this surgery is to some extent discretionary. Thus, to the extent that some of these surgical procedures could be avoided, some of the associated mortality might be reduced. Using 1979-1980 data, this study examines mortality up to a year after seven common operations--cholecystectomy, prostatectomy, inguinal hernia repair, cataract removal, arthroplasty of the hip, reduction of fracture of the femur, and coronary bypass--comprising about one-quarter of operations for aged Medicare enrollees. A followup study will investigate the question of whether an association exists between mortality rates and annual volume of operations performed at individual hospitals. The followup study will also describe the rehospitalization experiences of patients undergoing surgery.

Status: Preliminary results show that the risk of dying markedly increases with age and that patients operated on for prostatectomy and hip repair have higher than average mortality for up to a year following the operation. Preliminary results also show lower post-surgical mortality in the West for several operations. It is anticipated that an article will be published in the Health Care Financing Review in late 1984, and that a working paper on the followup study will be ready by late 1984 or early 1985.

Study of High-Cost Infants Under Medicaid

Funding: Intramural
Project Jerry Riley
Director: Division of Beneficiary Studies

Description: This study will focus on infants who incur high levels of reimbursements under the Medicaid program. Michigan data for 1980 and 1981 from the Health Care Financing Administration's "Tape-to-Tape" project will be used, with more States to be added if data become available in time. The study will focus on costs, diagnoses, services, incidence (in Medicaid), and mortality rate for such infants.

Status: This study was recently initiated. Extensive data processing activities must be completed before most analyses can begin. Preliminary data indicate that in 1982 there were about 500 hospitalizations for premature birth in Michigan, with average hospital costs of about \$11,000. It is anticipated that a working paper will be completed by late 1984 or early 1985.

Changes in the Distribution of Medicare Expenditures

Funding: Intramural
Project Jerry Riley
Director: Division of Beneficiary Studies

Description: A large portion of Medicare expenditures has historically been concentrated on a small number of beneficiaries who are heavy users of services. The question often arises as to whether expenditures under the program have become more or less concentrated over time among small numbers of high-cost individuals. This study will compare distributions of Medicare reimbursements for 1969, 1975, and 1982. The distribution of 1980 expenditures for the non-Medicare population, as reported in the National Medical Care Expenditure and Utilization Survey, will also be examined.

Status: Preliminary data indicate that Medicare reimbursements may have become slightly less concentrated in recent years. A working paper will be developed by November 1984.

Medicare/Medicaid Data Book

Funding: Intramural
Project Aileen Pagan-Berlucchi
Director: Division of Program Studies

Description: This report provides descriptive statistics on the organization and operation of the Medicare and Medicaid programs. It features cross-program comparisons on recent trends in program recipients, expenditures, and service utilization as well as in-depth discussions of the basic operating principles of each program. Several appendixes are also included that detail relevant studies on selected issues in each program, sources of information contained in the book, and the names and addresses of program officials at the Federal and State levels. This report is intended as a resource tool for public officials, researchers, policy analysts, and health care consumers and providers.

Status: The Medicare and Medicaid Data Book, 1983 has been published and is available from the Government Printing Office. For ordering information, contact: Office of Research and Demonstrations, Publications and Information Resources Staff, Rm. 2-E-6, Oak Meadows Building, 6325 Security Boulevard, Baltimore, Md. 21207 (301) 597-2422. The 1984 edition is in production.

Program Statistics Series Reports

Funding: Intramural
Project: Herbert Silverman
Director: Division of Program Studies

Description: Based on administrative files and bills submitted for Medicare-covered services for program beneficiaries, statistical reports are issued on a regular basis that provide data on the number and characteristics of program beneficiaries; the number, distribution, and characteristics of providers certified to furnish services to Medicare enrollees; and the patterns of use of program benefits by beneficiaries. Use of benefits is examined by the characteristics of the persons using them, the providers furnishing the services, and the distribution of charges and reimbursements to beneficiaries and providers. The purpose of these reports is to show trends and to examine the factors that may be influencing those trends.

Status: The following reports are either published or have been sufficiently developed that usable data are available:

- "Medicare: Use of Short-Stay Hospitals by Aged and Disabled Inpatients, 1978."
- "Medicare: Use of Physicians' Services under the Supplementary Medical Insurance Program, 1975-1978."
- "Medicare: Participating Health Facilities, 1974-1979."
- "Medicare Summary: Use and Reimbursement by Person, 1979."
- "Medicare: Use of Skilled Nursing Facilities, 1979."
- "Medicare: Use of Home Health Services, 1980."

The following reports are planned:

- "Medicare: Use of Hospital Outpatient Services, 1981."
- "Medicare: Use of Short-Stay Hospitals by Aged and Disabled Inpatients, 1980."
- "Medicare: Use of Skilled Nursing Facilities, 1981."
- "Medicare: Use of Home Health Services, 1982."

Program Evaluation

State Mortality Statistics

Project No.: RFC-83-2-504
Period: June 1983 - February 1984
Funding: \$ 236,310
Contractor: Association for Vital Records and Health Statistics
P.O. Box 231
Portland, Oreg. 97207
Project Officer: James Lubitz
Division of Beneficiary Studies

Description: The purpose of this contract is to obtain permission from States to use their death certificate data directly from the National Center for Health Statistics (NCHS). Authorizations have now been given, and mortality data for 1979, including cause of death, have been linked to Medicare records for a sample of 65,000 Medicare enrollees through a direct computer match. The contract represents a major advance in the efficient use of vital records. Researchers normally must request records from each State and then must code and enter information from hard-copy records. The resulting data file will be used for studies on the relationship of use and costs of Medicare services to cause of death. The data will be used as comparison data in the evaluation of the Medicare hospice benefit.

Status: The contractor has contacted 54 vital registration areas and 52 permissions have been received for a direct computer link between mortality and Medicare records.

Time Series Variation Rate Study of Medical Care Problem Areas Identified and Affected by PSRO MCE Studies

Project No.: 500-78-0050
Period: September 1978 - June 1983
Funding: \$ 703,110
Contractor: Corbin Associates, Inc.
1210 Corbin Court
McLean, Va. 22101
Project Officer: Gerald S. Adler
Division of Beneficiary Studies

Description: As part of the Health Care Financing Administration's evaluation of the Professional Standards Review Organizations (PSRO) program, this study assessed the effects of the Medical Care Evaluation (MCE) studies conducted under PSRO auspices. MCE's were conceived as the mechanism, based on the medical audit method, by which PSRO's assured that quality of care was maintained and improved. The study assessed adherence to objective standards of care before and after MCE's were done to see whether changes in compliance could be detected. It also estimated the benefits and costs associated with MCE's and the factors which facilitated or hindered PSRO quality assurance programs.

Status: Completed. The interim report of this project, which is contained in the 1979 Departmental evaluation of the PSRO program, showed that quality assurance had increased compliance with standards. No direct relationships were found between the improvements and such variables as hospital size, location, ownership, teaching affiliation, or MCE delegation status. This is one of the few large-scale quality of care evaluations. The summary volume of the final report has been received and will be made available through the National Technical Information Service.

Medicaid Short-Term Evaluation

Project No.: 100-82-0038, Task Order 5
Period: March 1983 - January 1984
Funding: \$ 125,000
Contractor: Urban Systems Research and Engineering, Inc.
2067 Massachusetts Avenue
Cambridge, Mass. 02140
Project Officer: Gerald S. Adler
Division of Beneficiary Studies

Description: This is the second in a series of evaluative studies focusing on the effects of the Omnibus Budget Reconciliation Act of 1981 and subsequent legislation on the Medicaid program. The first study prepared the groundwork by specifying evaluation issues, data, and methods. The current study uses available data to address these policy issues, focusing particularly on eligibility changes, utilization by the institutionalized and dually eligible groups, and general program trends.

Status: Report in preparation. Will be available as a Working Paper in Spring 1984.

Medicaid Program Evaluation

Description: The Office of Research has begun a 3-year project which will assess the changes made in the Medicaid program as a result of recent legislation. The Medicaid Program Evaluation will focus principally on program changes since the Omnibus Budget Reconciliation Act of 1981, an Act which considerably increased State flexibility in determining eligibility, reimbursement, and coverage under the program. The Medicaid Program Evaluation addresses the implementation and impact of selected changes in the Medicaid program to provide knowledge for policy assessment and future legislative change. It is focused on a select list of issues and policy questions raised by recent legislation.

Status: Three contracts were awarded on September 30, 1983, to conduct the evaluation studies:

- La Jolla Management Corporation with subcontractors. SysMetrics will study home and community-based care and incentives for family care.
- Abt Associates with subcontractors Health Economics Research and Compass Consulting will study hospital reimbursement changes.
- James Bell Associates, with subcontractors Syracuse University, Urban Institute, and National Governors' Association will study freedom of choice, eligibility, cost-sharing, Federal financial participation, 1983 legislation, and prepare the annual synthesis.

The project will produce annual reports on all studies.

Medicaid Program Evaluation: Cluster I

Project No.: 500-83-0056
Period: September 1983 - September 1986
Funding: \$ 953,595
Contractor: La Jolla Management Corporation
11426 Rockville Pike
Rockville, Md. 20852
Project Officer: Gerald S. Adler
Division of Beneficiary Studies

Description: This project addresses two tasks as part of the Medicaid Program Evaluation. The first deals with the home and community-based waiver program. Under Section 2176 of the Omnibus Budget Reconciliation Act of 1981, States under a waiver may institute a variety of home and community-based services to individuals who "but for" the waiver would be in long-term care institutions. The following questions will be addressed. Has the program reduced institutionalization? Has the program reduced costs? Has there been cost shifting from other programs, specifically Titles XX of the Social Security Act and III of the Older Americans Act? Can we identify the elements of a successful program? The second task deals with financial incentives for family care. Although Section 2176 does not provide specifically for direct financial payments to family members, some waivers may provide for this. Also, several States provide financial support through direct payments or tax incentives to family members to encourage their assistance to their elderly relatives. The major questions are: What programs are in operation? What have been their costs and savings? Who are the beneficiaries of such programs, and what are their characteristics? What are the characteristics of functionally-limited persons living in the community that permit them to avoid institutionalization? What are the characteristics of successful programs?

Status: The contract was awarded September 30, 1983.

Medicaid Program Evaluation: Cluster II

Project No.: 500-83-0057
Period: September 1983 - September 1986
Funding: \$ 763,629
Contractor: Abt Associates
55 Wheeler Street
Cambridge, Mass. 02138
Project Officer: Gerald S. Adler
Division of Beneficiary Studies

Description: This project will address inpatient hospital reimbursement as part of the Medicaid Program Evaluation. To help bring hospital costs under control, the Omnibus Budget Reconciliation Act of 1981 granted the States new flexibility in the establishment of inpatient hospital reimbursement methodologies. Major questions are: What responses have States made to the options permitted by Federal law? Have reductions in expenditures resulted? Specifically, what has been the impact of the California program? Two other State programs will be studied for comparison. What have been the effects on recipients and providers of care? Have costs been shifted to private payers? To what degree and in what ways has the implementation of Medicare prospective reimbursement had an impact on State Medicaid programs?

Status: The contract was awarded September 30, 1983.

Medicaid Program Evaluation: Cluster III

Project No.: 500-83-0058
Period: September 1983 - September 1986
Funding: \$ 1,449,479
Contractor: James Bell and Associates, Inc.
1700 North Moore Street, Suite 1622
Arlington, Va. 22209
Project Officer: Gerald S. Adler
Division of Beneficiary Studies

Description: The project addresses several issues as part of the Medicaid Program Evaluation. The first is freedom of choice waivers. Under Section 2175 of the Omnibus Budget Reconciliation Act (OBRA) 1981, States may institute a variety of programs to reduce costs by limiting the provision under Medicaid which guarantees freedom of choice of provider. Major questions are: How have the States responded to this provision? Have there been program savings? How have access to and quality of health care been affected? The second is eligibility. OBRA 1981 contained several changes which directly and indirectly reduced the number of persons eligible for Medicaid. Major questions are: How have the States responded to these provisions? How have eligibility changes in related programs (AFDC and SSI) affected Medicaid enrollment? How have entitlement and expenditures been affected? How has the reduction in Medicaid coverage affected other assistance programs, out-of-pocket expenditures, and costs to hospitals and other payers? The third is cost-sharing. Under the Tax Equity and Fiscal Responsibility Act of 1982, States are permitted to impose nominal copayments, with certain limitations, to reduce program outlays, and to instill cost-consciousness on the part of the recipients. Major questions are: How have the States responded? What has been the effect of copayments on utilization and costs? The fourth is Federal financial participation. OBRA 1981 provides for the reduction of Federal matching funding for 3 years, beginning October 1, 1982, subject to certain exemptions. Major questions are: Which States were exempted from the reductions and for what reasons? How much did the Federal Government save? How did the States adjust to reduced funding? The fifth is 1983 legislative changes. The OBRA of 1983 and other relevant legislation may continue to make changes affecting Medicaid. Such changes may impact on the changes noted above or contain provisions that are totally new. In either event, major questions will be raised with respect to program implementation and costs. The final task of the project will be to provide for the preparation of an annual interpretation, a summary, and synthesis of evaluation results.

Status: The contract was awarded September 30, 1983.

Medicare Automated Data Retrieval System

Project No.: 500-83-0034
Period: August 1983 - September 1984
Funding: \$ 146,805
Contractor: Inter Systems Inc.
7640 Little River Turnpike
Annadale, Va. 22003
Project Officer: Paul Lichtenstein
Evaluative Studies Staff

Description: The Medicare Automated Data Retrieval System (MADRS) will reorganize the Medicare bill and payment records to improve the accessibility of the data. The Office of Research and Demonstrations has a continual need for 100-percent data by geographic region or on individual Medicare beneficiaries or providers for carrying out research studies and for evaluating demonstrations. The current 100-percent bill or payment record files are organized in weekly batches in health insurance claim (HIC) number sequence. To find records for any individual beneficiary, provider, or geographic region, it is necessary to search through all the tapes. MADRS proposes to sort the 100-percent bill payment record file into yearly files and then by geographic region (county) and HIC number. The MADRS system will be indexed by county, provider, and HIC number. Using MADRS, it would be possible to quickly locate the portion of the files where the required data is located and retrieve it for research and demonstration studies.

Status: The design phase of MADRS is complete and programming is currently underway. Data for 1980 through 1983 will be available for retrieval beginning in October 1984.

Uses of Quality Control Data for Medicaid Policy Research

Funding: Intramural
Project: Gerald S. Adler
Officer: Division of Beneficiary Studies

Description: The purpose of the project was to demonstrate the uses of a new data base for Medicaid program analyses. The data are based on Medicaid Quality Control (MQC), a process whose goal is to detect errors in program administration. In the MQC process, sample cases are reviewed. Verified information on these cases was used in this study to develop data on program enrollment and utilization which are not otherwise routinely available.

Status: Completed. A paper on "Uses of Quality Control Data for Medicaid Policy Research," by Gerald S. Adler and Michele C. Adler, was presented at the annual meeting of the American Public Health Association, November 1983.

Health Care Alternatives Within Title XIX: Evaluation of Alternative Reimbursement Methods to Providers of Primary Care Medical Services

Project No.: 11-P-98321/5
Period: April 1983 - March 1986
Funding: \$ 543,000
Grantee: Michigan Department of Social Services
300 South Capitol Avenue
Lansing, Mich. 48909
Project Officer: Gerald S. Adler
Division of Beneficiary Studies

Description: The study will examine the consequences of enrollment in innovative medical care organizations for the cost, effectiveness, quality, and accessibility of medical care provided to Medicaid populations in Michigan. The organizational types to be compared are:

- Health maintenance organizations (HMO's).
- Capitated ambulatory plans (CAP), which also are capitated but which do not cover inpatient, dental, long-term care, or personal care.
- Physician's primary sponsor plan (PPSP), which features case management but in which care is paid for on a fee-for-service basis.

These organizations form a continuum of provider risk, and are to be compared with standard fee-for-service care.

Status: A sample of 20,000 Medicaid recipients in Wayne County, Michigan, has been drawn, 10,000 randomly assigned to the PPSP and 10,000 to the comparison group. Enrollment in the PPSP program is growing more slowly than expected. Pre-enrollment studies of patient satisfaction have been conducted.

COVERAGE

End-Stage Renal Disease

National Kidney Dialysis and Kidney Transplantation Study

Project No.: 95-P-97887/0-02
Period: January 1981 - September 1984
Funding: \$ 776,750
Grantee: Battelle Memorial Institute
4000 N.E. 41st Street
Seattle, Wash. 98105
Project: Carl Josephson
Officer: Office of Research

Description: The purpose of this study is to analyze the impact of alternative types of therapy on end-stage renal disease (ESRD) patients. Patient outcomes are measured in terms of the patient's quality of life, quality of care, cost of care, and rehabilitation status. Data collection instruments included direct patient interviews, facility-based medical records abstracts, completion of patient medical expense diaries, and the Health Care Financing Administration program data records from entitlement forms, provider certification records, facility survey files, facility cost reports, facility and provider reimbursement records, and other medical information files.

Status: Data based on 850 ESRD patients receiving care under four different types of therapy from 11 renal dialysis centers and facilities were collected during the first 18 months of the study. The next 20 months were spent in the editing and analysis of the basic data and the preparation and publication of 25 supporting documents and 17 major papers. In general, the study found that patients are not randomly assigned to different treatment modalities and that case-mix differences do affect patient outcomes. There were significant differences in the measures of quality of care and quality of life by type of therapy, and these differences persisted after adjusting for differences in patient case mix. Also, significant declines in labor force participation were associated with onset of the renal disease. In the study, only about one-half of the patients used rehabilitation services, and their use of services varied significantly across types of treatment modalities. Among the patients in the study for whom peritoneal dialysis is most appropriate, the choice of continuous cycling peritoneal dialysis represents an increasingly attractive alternative to continuous ambulatory peritoneal dialysis or intermittent peritoneal dialysis, since the patients were found to have a lower incidence of peritonitis, fewer hospital admissions, and fewer days of hospitalization. Both short- and long-term complications are associated with organ transplantation. Serious complications are more likely to be present among ESRD patients who have experienced a failed transplant than among patients who have successfully functioning allografts. These differences, however, are not attributable to patient case-mix differences because the two patient transplant groups do not differ with regard to age, sex, race, education, and primary disease diagnosis.

The major papers were:

- "Case Mix, Treatment Modalities, and Patient Outcomes: Results of the National Kidney Dialysis and Kidney Transplantation Study."
- "A Comparative Assessment of the Quality of Life of Patients on Four Treatment Modalities."
- "Functional Impairment, Work Disability, and the Availability and Use of Rehabilitation Services by Patients with Chronic Renal Failure."
- "Labor Force Participation Among ESRD Patients."
- "Health Services Utilization and Disability Days: Indicators of the Quality of Patient Care Among ESRD Patients."
- "Premorbid and Post-Treatment Functional Limitations Among Patients with Chronic Renal Failure."
- "Complexities in the Treatment of ESRD: Economic Efficiency and Treatment Modality Prescription."
- "The Demographic Characteristics of the National Kidney Dialysis and Kidney Transplantation Study: A Comparison With the ESRD Population."
- "The Use of Rehabilitation Services by Patients With Chronic Renal Failure."
- "Peritonitis, Hospital Admissions, and Days Hospitalized Among Patients on CAPD and CCPD: A Comparative Assessment."
- "Extrarenal Complications Among Kidney Transplantation Recipients."
- "Travel Costs Incurred by ESRD Patients."
- "National Policies for Treatment of End-Stage Renal Disease."
- "A Comparative Assessment of the Quality of Life of Successful Kidney Transplant Patients According to Source of Graft."
- "ESRD Patient Preferences for Dialysis and Transplantation."
- "A Comparison of the Utilization of Hospital Services Among ESRD Patients on Four Treatment Modalities."
- "The Financial Status of ESRD Patients."

The final year of the study will be devoted to the analysis and preparation of additional analytical papers.

Physicians Who Care for End-Stage Renal Disease Patients: A National Study of Their Practices, Patients, and Patient Care

Project No.: 18-P-98174/9
Period: March 1982 - December 1983
Funding: \$ 308,978
Grantee: University of Southern California
175 Zonal Avenue
Los Angeles, Calif. 90033
Project: Benson Dutton
Officer: Division of Reimbursement Studies

Description: This project involved the design and conduct of a national physician-oriented study of the time and effort allocated to various professional activities and patient-care services. The target population included all physicians who render care to patients with end-stage renal disease (ESRD) and who participate in the program under the alternative reimbursement method. Such physicians represent more than 75 percent of the physicians who treat ESRD patients. The study is all inclusive in the sense that the physicians surveyed were asked to report on their entire practice and the full array of their professional activities.

Status: A final report was delivered in February 1984.

Design of a Demonstration and Assessment of Competitive Health Insurance Proposals in the End-Stage Renal Disease Program

Project No.: 14-P-98275/3-01
Period: April 1983 - March 1985
Funding: \$ 380,532
Grantee: The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037
Project Officer: Mel Bulkley
Division of Health Systems and Special Studies

Description: This project will determine the feasibility of demonstrations to test competitive financing approaches in the end-stage renal disease program, with possibilities including:

- Competitive bidding.
- Global capitation covering all medical care costs.
- Partial capitation covering only outpatient ESRD services.
- Voucher payment allowing patients to share in the financial savings of cost-reducing shifts.

If competitive approaches are feasible, the Urban Institute will develop the demonstration model and an evaluation design. The evaluation will consider:

- Structure of the experimental treatments.
- Methods to ensure randomization.
- Determination of appropriate capitation amounts.
- Design of a reinsurance system.
- Estimate of sample sizes.

Status: The grantee is placing priority on assisting the Health Care Financing Administration in the development of the design and evaluation of a demonstration of a competitive bidding beneficiary incentive model. The Urban Institute continued their efforts to develop useful and workable quality-of-care and case-mix or patient-severity measures. Investigation of transplant issues has also continued, with computer file access and manipulation concerns as a top priority.

Developing Incentive Systems to Increase the Supply of Cadaveric Kidneys for Transplants

Project No.: 14-P-98333/1-01
Period: June 1983 - June 1985
Funding: \$ 297,414
Grantee: Brandeis University
415 South Street
Waltham, Mass. 02254
Project Officer: Paul W. Eggers
Division of Beneficiary Studies

Description: Using survey methodologies, this project will evaluate alternative approaches to increasing the participation of nongovernmental actors in organ procurement programs. The end result of the research will be a set of Health Care Financing Administration policy recommendations designed to improve the effectiveness of organ procurement networks and so increase the number of kidneys available for transplantation.

Status: The grant was initiated June 1983. Currently, the project is in the data collection phase.

Case-Mix Differences Between End-Stage Renal Disease Facilities

Funding: Brandeis University Health Policy Consortium
(See page 132)
Project Officer: Paul W. Eggers
Division of Beneficiary Studies

Description: This project examines end-stage renal disease patient characteristics that could impact on facility costs. Using patient history data from the Michigan Kidney Registry, survival analyses were performed to determine predictors of patient outcomes. Patient outcomes will then be correlated with Medicare patient utilization and charge information.

Status: The patient outcome work has been completed. The cost and use analyses are currently being conducted. Four papers have been produced:

- "Case-Mix in End-Stage Renal Disease: Differences Between Patients in Hospital-Based and Freestanding Facilities," submitted to New England Journal of Medicine.
- "An Overview of Case-Mix and Reimbursement," available from Brandeis Health Policy Consortium.
- "Initial Patient Characteristics and Risk in End-Stage Renal Disease: The Development of Severity Groupings Through a Survival Analysis," available from Brandeis Health Policy Consortium.
- "Analysis of Transfer Patterns Between Hospital and Freestanding Facilities," available from Brandeis Health Policy Consortium.

Kidney Procurement in the United States

Funding: Brandeis University Health Policy Consortium
(See page 132)
Project Officer: Paul W. Eggers
Division of Beneficiary Studies

Description: This project examines the organizational and structural characteristics of organ procurement agencies that impact on their ability to procure and supply cadaver kidneys. The project initially examined independent organ procurement agencies and then expanded to hospital-based agencies.

Status: This project has resulted in four papers:

- "Obtaining Replacements: The Organizational Framework of Organ Procurement," Journal of Health Politics, Policy and Law, Summer 1983.
- "Encouraging Altruism: Public Attitudes and the Marketing of Organ Donation," Milbank Memorial Fund Quarterly, Spring 1983.
- "Organizational Effectiveness in Organ Procurement: A Study of Independent Organ Procurement Agencies," available from Brandeis Health Policy Consortium.
- "Organ Procurement in the Netherlands and United States; A Comparison," Proceedings of the European Transplant Coordinators Meeting, 1983.

Relative Effectiveness and Cost of Transplantation and Dialysis in End-Stage Renal Disease

Project No.: 14-P-98372/5-01
Period: September 1983 - September 1988
Funding: \$ 1,110,383
Grantee: University of Michigan
Department of Epidemiology
109 Observatory Street
Ann Arbor, Mich. 48109
Project Officer: Carl Josephson
Division of Program Studies

Description: This study will perform a comprehensive assessment of the cost effectiveness of end-stage renal disease treatment under different treatment modalities, an assessment of the impact of Cyclosporin A on transplant success, and a life table analysis of risk factors for patient and graft survival. The study will use data from the Michigan Kidney Registry, supplemented by survey information and medical record abstractions. Because of the design of the study, it is anticipated that the project will demonstrate the utility of a longitudinal, patient-specific data system for policy decisionmaking at the Federal level.

Status: The project is just starting and no significant status indicators are available at this time.

Organ Donor Education Project

Project No.: 14-P-98437/0-01
Period: September 1983 - September 1984
Funding: \$ 41,410
Grantee: Oregon Donor Program
P.O. Box 532
Portland, Oreg. 97207
Project Officer: Melvin Bulkey
Division of Health Systems and Special Studies

Description: The purpose of the demonstration is to test whether the number of organ donors would be increased by the use of videotapes aimed at increasing public awareness of the need for organs. Two tapes will be produced--a public education tape to be shown to applicants for drivers' licenses in 60 Oregon Department of Motor Vehicle (DMV) Offices, and an informational tape to train DMV personnel to promote organ donation.

Status: The demonstration will be implemented after approval of the audiovisual materials. The evaluation plan is currently being reviewed.

Inexpensive Wrist-Wearable Artificial Kidney for 24-Hours-a-Day, 7-Days-a-Week Hemodialysis

Project No.: 18-C-98462/6-01
Period: September 1983 - March 1984
Funding: \$ 20,000
Grantee: Vitor, Inc.
2145 Stanmore Drive
Houston, Tex. 77019
Project Officer: Paul W. Eggers
Division of Beneficiary Studies

Description: This is a small business innovation research project. The intent of the study is to begin the design and testing of a miniature artificial kidney which could be worn on the wrist like a bracelet. This machine could be worn for as long as 1 week. It will use small replaceable dialyzer cartridges. The testing phase will involve measuring the efficiency of the wrist dialyzer against the larger dialysis machines, in laboratory animals.

Status: The project was initiated in September 1983.

Costs, Outcomes, and Competition in the End-Stage Renal Disease Program

Project No.: 18-P-98056/3
Period: August 1981 - September 1984
Funding: \$ 407,096
Grantee: The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037
Project Officer: James Cantwell
Division of Reimbursement Studies

Description: This project will aid in the overall assessment of the End-Stage Renal Disease (ESRD) program by studying three aspects:

- The determinants of the total cost of the program.
- Some measures of the health outcomes produced by the program.
- Alternative ways of organizing and improving the services.

Particular attention will be given to the effects of competition on the cost and quality of care among facilities in an area.

Status: Three major papers have been produced thus far under this grant:

- "Pro Competitive Health Insurance Proposals and their Implications for the ESRD Program."
- "Competition and Efficiency in the ESRD Program."
- "Financial Incentives and Policy Goals of the End-Stage Renal Disease Program."

The first paper concludes that there are numerous ways to induce more competitive behavior in the delivery of ESRD service, especially maintenance dialysis, although there are significant implementation problems with some strategies. The second paper concludes that analysis of cost alone cannot determine appropriate reimbursement levels, because that determination requires a prior political decision of the appropriate level of amenities. The third paper concludes that the precise legislative intent regarding the goals of the ESRD program is ambiguous, particularly to treatment objectives.

Medicare End-Stage Renal Disease Experience

Funding: Intramural
Project: Paul Eggers
Director: Division of Beneficiary Studies

Description: This study examines overall trends in the Medicare end-stage renal disease (ESRD) program. Changes in incidence, prevalence, and patient survival will be explored. In addition, changes in patient characteristics such as age, sex, race, and diagnosis will be documented. Medicare reimbursements for ESRD patients will be analyzed as well, including hospital costs, physician costs, and outpatient dialysis costs. Special analyses will be done on transplant patients.

Status: The following papers and reports have been generated from this study:

- "Life Expectancy and Use of Services by Persons With End-Stage Renal Disease Enrolled in Medicare," Paper presented at the American Public Health Association Annual Meeting, New York, 1979.
- "Analyses of Indicators of Case-Mix Differences Between Freestanding Facility and Hospital-Based Medicare ESRD Patients," Working Paper No. OR-33, Office of Research and Demonstrations, Health Care Financing Administration, May 1982.
- "Trends in Incidence, Prevalence, Survival, and Reimbursement in Medicare ESRD Patients," Working Paper No. OR-40, Office of Research and Demonstrations, Health Care Financing Administration, April 1982.
- "Medicare Program Experience With End-Stage Renal Disease," Paper presented at the New York Academy of Sciences, New York, January 1983.
- "Uses of the End-Stage Renal Disease Medical Information System for Epidemiological Research," Paper presented at the National Nephrology Foundation, New York, January 1983.
- "The Medicare Experience With End-Stage Renal Disease: Trends in Incidence, Prevalence, and Survival," Health Care Financing Review, Spring 1984 issue.
- "Cost-Effectiveness of Kidney Transplantation: An Analysis of the Pay-Back Time for Transplant Patients," Proceedings of the 19th National Meeting of the Public Health Conference on Records and Statistics, Washington, D.C., August 1983.

Urban Clinics

Urban Health Clinics Demonstration

Project No.: 500-81-0048
Period: September 1981 - December 1985
Funding: \$ 891,089
Contractor: Technassociates, Inc.
1700 Rockville Pike, Suite 200
Rockville, Md. 20852
Project Officer: John F. Meitl
Division of Health Systems and Special Studies

Description: The Rural Health Clinics Act of 1977 (Public Law 95-210) mandated that the Department of Health and Human Services conduct demonstrations in urban medically underserved areas to test the relative advantages and disadvantages of cost-based and fee-for-service reimbursement for physician-directed clinics that employ physician extenders (physician assistants or nurse practitioners). The demonstration will involve approximately 40 clinics in California and Tennessee. An appropriate definition of medically underserved areas will also be established by the Public Health Service.

Status: The 2-year operational phase began on August 1, 1983, in 10 clinics in Tennessee and 30 clinics in California. The demonstration clinics are evenly divided, with 13 having a cost-based reimbursement, 14 having fee-for-service reimbursement, and the remaining clinics serving as controls. The first round of site visits to validate the cost reports and other data were conducted during the first quarter of 1984. The Office of Direct Reimbursement, Health Care Financing Administration, is serving as the fiscal agent for all demonstration clinics. Through January 31, 1984, 12,000 bills had been received and processed. Arthur D. Little, Inc., is conducting the evaluation of the project.

Evaluation of the Urban Health Clinics Demonstration

Project No.: 500-82-0025
Period: September 1982 - August 1986
Funding: \$ 806,666
Contractor: Arthur D. Little, Inc.
Acorn Park
Cambridge, Mass. 02140
Project Officer: Tony Hausner
Evaluative Studies Staff

Description: The purpose of this contract is to evaluate the Urban Health Clinics Demonstration (Project No. 500-81-0048). The evaluation will focus on use, cost, and quality of services.

Status: The data resources report and literature review were completed January 1983. The research design report and final report were delayed because of delays in implementation of the demonstration. The design report was submitted in December 1983 and the final report is expected in August 1986.

Technology Costs

Proposal to Develop a Plan for a Private/Public Sector Entity for Assessing Technology in Medical Care

Project No.: 18-P-98348/3-01
Period: May 1983 - November 1983
Funding: \$ 20,000
Grantee: National Academy of Sciences
Institute of Medicine
2101 Constitution Avenue, N.W.
Washington, D.C. 20418
Project Officer: Joel Broida
Division of Economic Analysis

Description: This grant was awarded to partially support the development of a plan for a private/public entity for the assessment of medical care technologies. The total amount of the grant was \$133,165, with the Health Care Financing Administration contributing \$20,000. A committee, appointed by the President of the Institute with the approval of the President of the National Academy of Sciences, served as representatives of interested parties, including professional groups, government, private insurance, business, labor, health care institutions, manufacturers of health care products, methodological experts, and consumers. The committee drafted a specific plan for private and public sector activity on technology assessment in medical care. The plan defined the mission of the new entity which might be established, identified the composition of the advisory group, outlined possible short-term and long-term roles of the Institute, formulated a budget, and suggested mechanisms for support of the continuing effort.

Status: The committee recommended the creation of a Medical Technology Assessment Consortium, a part of the Institute of Medicine. They plan to seek support for the Consortium from governmental and nongovernmental sources. The Consortium would serve as a clearinghouse, provide "secondary assessment," identify needs for technology assessment, and provide education and training to those interested in technology assessment. More detailed information on the scope of these activities is available in the report: "Planning Study Report--A Consortium for Assessing Medical Technology," Institute of Medicine, IOM-83-05, Washington, D.C., Nov. 1983.

Technology Assessment for Insurance Coverage Decisions

Funding: Brandeis University Health Policy Consortium
(See page 132)
Project Officer: Joel Broida
Division of Economic Analysis

Description: Massachusetts Institute of Technology (MIT), a part of the University Health Policy Consortium, has undertaken a two-part study involving technology assessment for insurance coverage decisions. The first part of the study looks at the decisionmaking process used by the National Center for Health Services Research regarding Medicare coverage of new technologies. Two samples of technological innovations have been drawn. The first consists of 11 procedures that are being studied in depth. The second sample consists of 51 procedures less intensively studied. The second part of the study is to identify the factors and weights related to the coverage decisions and to examine how they influence the coverage recommendations.

Status: The study is nearing completion. A draft report of the findings is being completed and will be submitted when the grant ends.

Clinical Social Worker

Medicare Clinical Social Worker Demonstration

Project No.: 500-82-0053
Period: September 1982 - December 1985
Funding: \$ 441,345
Contractor: SRI International
333 Ravenswood Avenue
Menlo Park, Calif. 94025
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: The Omnibus Reconciliation Act of 1980 (Public Law 96-499) mandated that the Department of Health and Human Services conduct a demonstration to determine the effects of making the services of clinical social workers more generally available under Medicare. The demonstration will allow direct reimbursement to clinical social workers for their services rather than through a physician or clinic. This contract is for the design and implementation of the direct reimbursement demonstration. There will be a separate contract awarded for the evaluation.

Status: In the initial phase of the project, the contractor has identified the demonstration sites and carriers who will process claims and collect information. Southern California is the experimental site with Transamerica Occidental as carrier, and Northern California is the control site with Blue Shield of California as carrier. Initiation of services by clinical social workers is planned for January 1984. Major tasks accomplished in the last 6 months were related to administrative claims processing systems to be implemented by the Medicare carrier in the test site, awareness marketing to the clinical social workers in Southern California, and a survey questionnaire to clinical social workers in both sites conducted by mail to determine current practice settings. Some 1,500 clinical social workers out of 4,000 practicing in the 7 Southern California counties have signed up to participate.

Other Coverage

State Policies and Procedures for Determining Medicaid Coverage for Newborns

Project No.: 18-P-97906/5-02
Period: January 1981 - January 1983
Funding: \$ 95,339
Grantee: American Academy of Pediatrics
1801 Hinman Street
Evanston, Ill. 60204
Project Officer: Judith Sangl
Division of Economic Analysis

Description: This study attempts to identify the variety of State Medicaid policies relating to the coverage of newborns and to present realistic options for overcoming the problems created by the current policies. Identifying problematic policies will improve the preventive care available to children eligible for Medicaid.

Status: The first phase of the study has documented the varieties of rules, regulations, and practices that exist among the 50 programs that potentially may deny medical care necessary for newborns or that, in operation, tend to discourage hospitals and physicians from accepting Medicaid patients. The specific rules regarding time and place of application and regulations, such as those requiring billing for services under a newborn's own eligibility number, can act to limit Medicaid coverage of newborns. Within the framework of existing rules, various practices are in operation that may facilitate or prevent the prompt establishment of eligibility. The final report is expected in mid-1984.

Study of Medicare Funded Heart Transplants

Project No.: 500-81-0051
Period: September 1981 - June 1984
Funding: \$ 1,270,000
Contractor: Battelle Human Affairs Research Centers
4000 N.E. 41st Street
Seattle, Wash. 98105
Project Officer: Joel Broida
Division of Economic Analysis

Description: This project is an evaluation of the scientific, economic, ethical, and social consequences of Medicare coverage for heart transplants. The study will evaluate the survival rates of heart transplant patients and the total costs of transplantation. It will additionally perform an analysis of organ donation, examine the field of organ procurement, and attempt to determine the legal and ethical implications of transplantation while controlling for perceived quality of life.

Status: For the most part, the data collection and coding phases of this project have been completed. Survival and cost analyses are currently underway. In addition, data on need, organ procurement, legal aspects, and ethical issues are in varying stages of either data compilation or analysis. The final report is expected to be completed by Summer 1984.

Medicare Mental Health Demonstration

Project No.: 500-80-0046
Period: July 1980 - October 1983
Funding: \$ 736,000
Contractor: Executive Resource Associates
1745 Jefferson Davis Highway
Suite 612 Crystal Square 4
Arlington, Va. 22202
Project Officer: Melvin Bulkley
Division of Health Systems and Special Studies

Description: This demonstration tested the cost effectiveness and impact of expanded Medicare coverage of outpatient mental health services provided in freestanding community mental health centers and partial hospitalization facilities. Services provided by nonphysician mental health professionals were covered, beneficiary cost-sharing requirements were relaxed, and reimbursement was made on a cost-related basis. The contract provided technical assistance in the implementation and monitoring of the demonstration requirements in the 40 participating facilities.

Status: The demonstration has been completed and a final report on its implementation has been received. Near the end of its operational phase, 7,000 beneficiaries had received services and \$9 million had been paid to the facilities for these services. The implementation contractor made two visits to each facility to verify that they were complying with requirements. Utilization had increased, especially for beneficiaries 65 years of age and over and beneficiaries with no previous mental health treatment. Evaluation of the demonstration is being performed under a separate contract by Macro System, Inc.

Evaluation of the Medicare Mental Health Demonstration

Project No.: 100-80-0148
Period: September 1980 - June 1984
Contractor: Macro System, Inc.
8630 Fenton Street
Silver Spring, Md. 20910
Co-Project Officer: Sharman Stephens
Office of the Assistant Secretary for Planning and Evaluation
Tony Hausner
Evaluative Studies Staff

Description: This project evaluates the utilization and cost implications of a demonstration encompassing 40 sites that waives the physician supervision requirements for Medicare reimbursement to mental health centers. Study areas will focus on assessment of impact of this waiver on mental health services, utilization patterns, overall cost to the Medicare program, and administrative and operational capacity of the participating mental health centers. The Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, is funding this project and administering it jointly with the Health Care Financing Administration.

Status: The research design was completed in August 1981, and the study is underway. A final report is expected in June 1984.

Study of the Impact of Rural Health Clinics on the Use of Inpatient Hospital Services

Project No.: 18-P-98061/1-02
Period: August 1981 - August 1983
Funding: \$ 118,881
Grantee: Medical Care Development, Inc.
11 Parkwood Drive
Augusta, Maine 04330
Project Officer: John Petrie
Division of Reimbursement Studies

Description: This study will determine the impact on inpatient hospital use and expenditures of increased access to primary care in areas served by federally funded rural health clinics (RHC's). The researchers expect to learn whether RHC care serves as a substitute for inpatient care, thereby reducing total medical costs of patients in rural communities, or as a complement to inpatient care, thereby increasing these patients' medical costs.

Status: Medical Care Development has selected target and control areas for the study and secured and coded three sets of data: RHC encounter data, hospital discharge data, and Maine population data. Preliminary findings indicate that the use of inpatient hospital services by Medicare beneficiaries (and inpatient hospital expenditures for these beneficiaries) may be higher in areas served by RHC's, compared with rural areas not served by RHC's. More comprehensive findings and a final report are expected in March 1984.

Study to Evaluate the Impact of Rural Health Clinic Services

Project No.: 18-P-97625
Period: July 1980 - June 1983
Funding: \$ 416,515
Grantee: University of Washington
Department of Health Services
802 Coach House
2309 N.E. 48th
Seattle, Wash. 98105
Project Officer: Alan Friedlob
Evaluative Studies Staff

Description: The project goal is to assess the contribution of the Rural Health Clinics Act of 1977 (Public Law 95-210) to the development and function of rural health clinics. The study focuses on examining rural health clinics in Idaho and Washington. The study evaluates the use of rural health clinics in these two States by Medicaid beneficiaries and through application of tracer disease methodology, and focuses on the treatment costs for common illnesses at rural health clinics, compared with noncertified clinics and physicians' offices.

Status: A final report will be available by Spring 1984.

California State Copayment Project

Project No.: 11-P-98206/9-02
Period: March 1982 - March 1985
Grantee: California Department of Health Services
714/744 P Street
Sacramento, Calif. 95814
Project: John F. Meitl
Officer: Division of Health Systems and Special Studies

Description: The purpose of this project is to determine if nominal copayments will reduce inappropriate use of health services while not affecting needed services. Copayments are limited to ambulatory services and are collected by the provider. Early and Periodic Screening, Diagnosis, and Treatment eligibles and Medicare beneficiaries are exempt from all copayments. Copayments are, with some exceptions: \$1 for each outpatient clinic, or physician-type visit; \$5 for each visit for nonemergency services received in an emergency room; and \$1 for each drug prescription.

Status: The State has completed a 1982-83 provider survey. The response rate to the survey was 80 percent. The majority of providers were aware that some Medi-Cal beneficiaries have to copay and more hospital emergency rooms are collecting copayments than any other providers (64.9 percent): 17.2 percent of the emergency rooms indicated that copayment has discouraged patients from seeking care for nonemergency conditions. These findings are preliminary; a more in-depth analysis of the survey will be contained in the final report. The demonstration was implemented on May 10, 1982.

Medigap Study of Comparative Effectiveness of State Regulations

Project No.: 500-81-0050
Period: September 1981 - May 1984
Funding: \$ 1,258,757
Contractor: SRI International
333 Ravenswood Avenue
Menlo Park, Calif. 94025
Project Officer: Judith Sangl
Division of Economic Analysis

Description: This study will evaluate the effectiveness of various State regulatory approaches for health insurance sold to the elderly. It contains both a consumer survey of Medicare beneficiaries and an industry survey of the companies who sell insurance to them. It will be conducted in six States.

Status: The final report of the consumer survey was submitted in Fall 1983. The report found that three State actions impacted on the purchase of higher quality policies. They are:

- Establishing minimum benefit requirements.
- Setting minimum loss ratios.
- Distributing consumer guides.

Although State regulations seem to have less impact on sales abuse, two strategies--distributing consumer guides and issuing press releases when companies or agents are found guilty of misrepresentation--appear to have some beneficial effect. Finally, the distribution of consumer guides was associated with greater consumer knowledge of Medicare or of the policies purchased. The final report of the consumer survey was available in Fall 1983. Data collection for the industry survey began in June 1983, and the final report on the project is expected in May 1984.

Evaluation of Obstetrical Access Pilot Project

Project No.: 11-P-97578/9-02
Period: March 1980 - June 1984
Funding: \$ 203,370
Grantee: Department of Health Services
714 P Street
Sacramento, Calif. 95814
Project Officer: Tony Hausner
Evaluative Studies Staff

Description: The purpose of this grant is to conduct an evaluation of the Obstetrical Access Pilot Project (Project No. 11-P-97223/9-03) which was completed in March 1983. The project tested the hypothesis in 10 clinical sites that the provision of early access to obstetrical services for low-income pregnant women would reduce subsequent morbidity of both infants and mothers. Services included health education, nutrition, and psychosocial assessments in addition to prenatal, delivery, and postpartum services.

Status: The research design was completed in December 1981. An interim report was prepared in December 1982 for submission to the State legislature. A key finding is that the project reduced the rate of low-birthweight babies. The final report is expected in June 1984.

Impact of Psychological Intervention on Health Care Utilization and Costs: A Prospective Study

Project No.: 11-P-98344/9-01
Period: September 1983 - September 1988
Funding: \$ 955,000
Grantee: Hawaii State Department of
Social Services and Housing
P.O. Box 339
Honolulu, Hawaii 96809
Project Officer: Andrew K. Solarz
Division of Health Systems and Special Studies

Description: The goal of this demonstration is to conduct a prospective study on the island of Oahu, Hawaii of approximately 3,124 randomly selected Medicaid high health care utilizers who will be provided short-term psychosocial intervention counseling. A private sector health maintenance organization group on the island also will be studied. The impact of the treatment upon health care utilization and costs will be evaluated. The subcontractor, the Institute of Psychological Interaction of Palo Alto, Calif., will implement and evaluate the study.

Status: The focus of the project during the first 9 months is on the recruitment and special training of clinical psychologists.

New Jersey Mobile Intensive Care System

Project No.: 95-P-98352/2-01
Period: November 1983 - October 1986
Grantee: New Jersey State Department of Health
CN 363
Trenton, N.J. 08625
Project Officer: Cynthia K. Mason
Division of Hospital Experimentation

Description: The purpose of the Mobile Intensive Care Unit (MICU) system is to demonstrate the cost effectiveness of New Jersey's approach to provision of emergency advanced life support services. Paramedics and advanced life support equipment are transported in the MICU vehicle while emergency patient transportation will continue to be provided by volunteer ambulance squads.

Status: Starting November 1, 1983, Medicare, Medicaid, and other third-party payers began covering MICU charges as an outpatient service. For Medicare, the charge is paid under Part B unless the patient is admitted to a hospital. Under such circumstances, the MICU charge is included on the inpatient bill. In addition, the Health Care Financing Administration has agreed to retroactively reimburse New Jersey hospitals under Part A for MICU services rendered during the period January-October 1983.

Evaluation of the Impact of Second Opinions for Elective Surgery

Project: 500-78-0047
Period: September 1978 - September 1983
Funding: \$ 2,225,791
Contractor: Abt Associates, Inc.
55 Wheeler Street
Cambridge, Mass. 02138
Project Officer: Alan Friedlob
Evaluative Studies Staff

Description: The objective of this evaluation is to determine the effect of formal second opinion programs on surgery rates, surgical costs, and the health of patients who forego surgery as a result of obtaining a second opinion. The basis of the evaluation is two voluntary Medicare Second Surgical Opinion Programs (SSOP) in New York City and Detroit, the State of Massachusetts' mandatory Medicaid SSOP, and the Health Care Financing Administration's (HCFA) public information second surgical opinion program.

Status: A major report has been produced. Based on this report, the Office of Research and Demonstrations, HCFA, prepared a report to Congress on the desirability of waiving Medicare cost-sharing for voluntarily sought second surgical opinions. This study is summarized in a brief report in the September 1982 issue of the Health Care Financing Review. A survey of 445 Medicare beneficiaries in New York City--both voluntary program users and control group beneficiaries (who were recommended for select procedures but who did not use the program)--has been completed. Five papers analyzing this data are in preparation and expected to be completed by Summer 1984.

Alcoholism Services Demonstration Projects

Period: September 1981 - December 1985
Project: Andrew K. Solarz
Officer: Division of Health Systems and Special Studies

Description: The following six projects are a collaborative demonstration between the Office of Research and Demonstrations, Health Care Financing Administration, and the National Institute on Alcohol Abuse and Alcoholism, Public Health Service. These demonstration projects are designed to test the feasibility and cost effectiveness of providing limited coverage for alcoholism treatment services given in freestanding (nonhospital) treatment centers. Each project is uniformly using the following service limits for Medicare and/or Medicaid services:

- Alcohol detoxification - No limit on episodes.
- Inpatient treatment - Up to 30 days per year.
- Outpatient treatment - Up to 45 visits per year.
- Halfway houses - If qualified, can render all of the above services.

Alcoholism Services under Medicare: Connecticut Demonstration

Project No.: 95-P-97968/1-03
Funding: \$ 324,789
Grantee: Connecticut Alcohol and Drug Abuse Commission
999 Asylum Avenue
Hartford, Conn. 06105

Status: Coverage of services in Connecticut was initiated July 1, 1982. The State has 12 providers participating in the demonstration in Medicare only. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the third year has been approved.

Alcoholism Services under Medicare and Medicaid: Illinois Demonstration

Project No.: 95-P-97971/5-03 (Medicare)
Funding: \$ 159,739
Grantee: Department of Mental Health and Developmental Disabilities
901 Southwind Road
Springfield, Ill. 62703

Project No.: 11-P-97972/5-03 (Medicaid)
Funding: \$ 182,000
Grantee: Department of Public Aid
931 East Washington Street
Springfield, Ill. 62703

Status: Coverage of services in Illinois was initiated July 1, 1982. The State has nine providers participating in the demonstration in both Medicare and Medicaid. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the third year has been approved. Illinois has developed a prospective rate for alcoholism services that will be used in the project.

Alcoholism Services under Medicare and Medicaid: Michigan Demonstration

Project No.: 95-P-97975/5-03 (Medicare)
Funding: \$ 59,053
Grantee: Office of Substance Abuse Services
Department of Public Health
3500 North Logan
Box 30035
Lansing, Mich. 48909

Project No.: 11-P-97976/5-03 (Medicaid)
Funding: \$ 277,346
Grantee: Medical Services Administration
Department of Social Services
300 South Capital Avenue
Lansing, Mich. 48909

Status: Coverage of services in Michigan was initiated July 1, 1982. The State has 22 providers participating in the demonstration in both Medicare and Medicaid. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the third year has been approved.

Alcoholism Services under Medicare and Medicaid: New Jersey Demonstration

Project No.: 99-P-97973/2-03
Funding: \$ 416,340
Grantee: Division of Medical Assistance and Health Services
325 East State Street
Trenton, N.J. 08625

Status: Coverage of services in New Jersey was initiated August 1982 for Medicare and in October 1982 for Medicaid. The State has 22 providers participating in the demonstration in both Medicare and Medicaid. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the third year has been approved.

Alcoholism Services under Medicare and Medicaid: New York Demonstration

Project No.: 99-P-97979/2-03
Funding: \$ 403,383
Grantee: Division of Medical Assistance
Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243

Status: Coverage of services in New York was initiated July 1, 1982. The State has 13 providers participating in the demonstration in both Medicare and Medicaid. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the third year has been approved.

Alcoholism Services under Medicare: Oklahoma Demonstration

Project No.: 95-P-97983/6-03
Period: September 1981 - December 1985
Funding: \$ 600,000
Grantee: American Indian Institute
University of Oklahoma at Norman
555 Constitution Avenue
Norman, Okla. 73037

Status: Coverage of services in Oklahoma was initiated July 1, 1982. The State has 18 providers participating in the demonstration in Medicare only. Provider staff has been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration awareness program has been developed within the target area. The continuation application for the third year has been approved.

Evaluation of the Alcoholism Services Demonstration

Project No.: 500-83-0023
Period: April 1983 - December 1986
Funding: \$ 2,644,996
Contractor: Lawrence Johnson and Associates, Inc.
4545 42nd Street, N.W.
Washington, D.C. 20016
Project Officer: Tony Hausner
Evaluative Studies Staff

Description: This is an evaluation of the effectiveness of the demonstration that expands Medicare and/or Medicaid coverage to freestanding alcoholism treatment centers. It will examine the impact of the demonstration on the use and cost of services. The project is supported by funds from the National Institute on Alcohol Abuse and Alcoholism, Public Health Service, and the Health Care Financing Administration.

Status: The research design was completed in March 1983. The contractor is currently implementing the research design. Data collection, analysis, and submission of interim and final reports will follow. The final report is due December 1986.

Foot Care Coverage Study

Funding: Intramural
Project William J. Sobaski
Director: Division of Reimbursement Studies

Description: Public Law 96-499, Section 958(g), directs the Secretary of the Department of Health and Human Services to conduct a study involving a comprehensive analysis of the cost effects of alternative approaches to improving coverage under Title XVIII of the Social Security Act for the treatment of various types of foot conditions. The study has involved meetings and discussions with professional and Federal experts; staff reviews of literature and relevant statistical information; a Federal Register notice soliciting information and comments from the public; a survey of State Plans for Medical Assistance; an independent study by the Center for Health Services and Policy Research at Northwestern University; and actuarial estimates of the costs of eliminating certain presently excluded or specially restricted types of expenses for treatment of foot conditions. The study will examine present Medicare benefits for the treatment of foot conditions as specified in the law and its implementing regulations and manuals. Possible ways for improving coverage will be identified, and the effects these changes could have upon beneficiary health status and on the pattern of sources now used for financing foot care treatment will be considered.

Status: The report is under development and should near completion in Fall 1984.

Registered Dietitians in Home Care

Funding: Intramural
Project Marni Hall
Director: Office of Research

Description: Section 958 of Public Law 96-499, the Omnibus Budget Reconciliation Act of 1980, directs the Department of Health and Human Services to conduct a study of "the circumstances and conditions under which services furnished by registered dietitians should be covered as a home health benefit under Title XVIII of the Social Security Act." The study has three objectives:

- To assess Medicare beneficiaries' needs for direct clinical counseling by registered dietitians in the home.
- To explore alternative methods for coverage and reimbursement.
- To estimate utilization rates and costs for the alternative methods of coverage and reimbursement.

Status: The draft report is currently under review by the Health Care Financing Administration. It is due to be submitted to the Secretary of the Department of Health and Human Services by Fall 1984.

Home Respiratory Therapy Services

Funding: Intramural
Project Marni Hall
Director: Division of Economic Analysis

Description: Section 958 of Public Law 96-499, the Omnibus Budget Reconciliation Act of 1980, requires that the Department of Health and Human Services conduct "a study of the circumstances and conditions under which services furnished with respect to respiratory therapy should be covered as a home health benefit under Title XVIII of the Social Security Act." This study evaluates these issues and examines the present "state of the art" in respiratory therapy and the current availability of respiratory therapy services. It also examines the medical and economic ramifications of expanding Medicare benefits to include those home services provided by respiratory therapists.

Status: The draft report is currently under review by the Health Care Financing Administration. It is due to be submitted to the Secretary of the Department of Health and Human Services by the end of 1984.

PREVENTION

Child Health

Health Care Services for Children Under Medicaid

Project No.: 18-P-98011/3
Period: August 1981 - September 1983
Funding: \$ 425,605
Grantee: Johns Hopkins University
School of Medicine
Department of Pediatrics
720 Rutland Avenue
Baltimore, Md. 21205
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: The Health Care Financing Administration approved a grant for a comparative study of health care services for children by using billing claims and eligibility data files from the State of Maryland. The grantee seeks information on the cost and effectiveness of services for children eligible for the Medicaid Early and Periodic Screening, Diagnosis, and Treatment Program. Data on the costs and utilization of services for children using private practitioners, hospital clinics, emergency rooms, and various combinations of delivery systems serve as the bases for this analysis.

Status: Accomplishments to date include:

- Meetings with State Medicaid agencies.
- Completion of preliminary analysis of Children and Youth Project data, and records of eligibility for input into the data base.
- Acquisition of eligibility tape files.
- Conversion of eligibility tape files and payment files.

The Medicaid eligibility files have been converted and reformatted into the data base management system. Summary variables have been programmed and run for these files. Payment and claims files conversion and preparation are complete. Using the data files from the Johns Hopkins Hospital Title V, children and youth clinic, utilization of services by Medicaid and self-pay patients have been compared. Hypotheses developed in these studies will be tested against the large State Medicaid file.

Prenatal Care and Its Relationship to Medicaid Costs

Project No.: 11-P-98305/7-02
Period: March 1983 - March 1985
Funding: \$ 78,679
Grantee: Missouri Division of Health
Broadway State Office Building
P.O. Box 570
Jefferson City, Mo. 65102
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: This project links birth certificate records with Medicaid obstetrical and newborn records. The combined data set will be used to study the obstetrical and newborn Medicaid costs associated with women who receive preventive prenatal services as opposed to those who do not receive adequate services. The primary goal of the project is to determine if the Medicaid coverage provided for Medicaid mothers obtaining adequate prenatal care is cost-beneficial.

Status: The 1981 Medicaid newborn tape was created. Matching between newborn and mother's records using the original method and a cross-reference file was 91 percent. A match of the 1981 Medicaid tape with the 1981 birth tape achieved a match rate of 88 percent between the two files. The 1982 Medicaid newborn tape was created and is currently being checked. Matching between newborn and mother's records was about 86 percent. All work tasks are proceeding on schedule.

Other Prevention

Municipal Health Services Program

Project No.: Cooperative Agreement
Period: August 1979 - December 1984
Participants: Baltimore, Md.
Cincinnati, Ohio
Milwaukee, Wis.
St. Louis, Mo.
San Jose, Calif.
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: Municipal Health Services Program (MHSP) is a collaborative effort of five major cities in five States, the U.S. Conference of Mayors, the Robert Wood Johnson Foundation (RWJF), and the Health Care Financing Administration (HCFA). It was initiated by RWJF through grants of \$3 million awarded in June 1978 to each of the following five cities: Baltimore, Cincinnati, Milwaukee, St. Louis, and San Jose. HCFA joined in the project by providing Medicare waivers through a cooperative agreement and Medicaid waivers through grants to 4 of the 5 States to test the effects of increased utilization of municipal health centers by:

- Eliminating coinsurance and deductibles.
- Expanding the range of covered services.
- Paying the cities the full cost of delivering services at the clinics.

The intent of the waivers is to shift fragmented utilization away from costly hospital emergency rooms and outpatient departments toward lower cost Municipal Health Services Program (MHSP) clinics which would provide beneficiaries with comprehensive primary and preventive health care.

Status: The first city began billing under the Medicare waiver in August 1979. Four of the five cities (all except Cincinnati) desired to use Medicaid waivers as well, and this brought in participation of the State Governments in 1981. As of January 1983, the five MHSP cities have a total of 19 clinics operating, bringing together both public and private health-related organizations. A wide variety of services are offered, including medical, social, mental, preventive, dental, optometry, podiatry, and rehabilitation. Clinic utilization ranges widely from 700 visits per year to 40,000 visits per year. Average provider productivity ranges from 3,200 to 4,500 annual visits per full-time equivalent provider. Waivers are scheduled to terminate December 1984.

Evaluation of Municipal Health Services Program

Project No.: 500-78-0097
Period: September 1978 - May 1984
Funding: \$ 3,105,250
Contractor: University of Chicago
5720 S. Woodlawn Avenue
Chicago, Ill. 60637
Project Officer: Tony Hausner
Evaluative Studies Staff

Description: This is an evaluation of the Municipal Health Services Program demonstrations. It is a collaborative effort with the Robert Wood Johnson Foundation. The evaluation covers the quality and efficiency of services delivered in urban clinics in five cities (Baltimore, Cincinnati, Milwaukee, St. Louis, and San Jose).

Status: The contractor has submitted interim reports covering the baseline survey and secondary data resources. The final report, which will include data from the followup survey, is expected in May 1984. Preliminary findings indicate that program users have lower health care utilization than other users in the service area.

Quality and Effectiveness of Preventive Medical Care

Project No.: 18-P-97777/9
Period: September 1980 - March 1984
Funding: \$ 596,804
Grantee: Rand Corporation
1700 Main Street
Santa Monica, Calif. 90406
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: This study focuses on the effect of preventive care on various categories of medical expenditure and any losses attributed to sickness. Issues and questions to be addressed include:

- The effects of preventive care on health status, medical care use, and work time available.
- The responsiveness of consumer demand to changes in the price of preventive care.
- The amounts of preventive care used in prepaid systems versus fee-for-service practice settings, both with no out-of-pocket charges.
- Whether or not people choosing the prepayment plan are fundamentally different in their desires to obtain preventive care.

The study will use data from the Rand Health Insurance Study (HIS), a social experiment in which families are assigned to several different health insurance plans. Approximately 8,000 individuals have been enrolled at six sites across the country: Dayton, Ohio; Seattle, Washington; Fitchburg, Massachusetts; Franklin County, Massachusetts; Charleston, South Carolina; and Georgetown County, South Carolina.

Status: The tasks for the 3-year study include the following. During the first year, working knowledge of the relevant HIS data was developed; computer programs will be constructed; literature review undertaken; and the analytic design will be refined. In the second year, analyses were performed on the Dayton, Seattle, and Fitchburg/Franklin 3-year sample data; and the analytic design and computer software further developed. The third year was spent extending the analysis to the 5-year samples, further developing the analytic design, and preparing reports. A final report is due in Spring 1984.

Prevention of Future Utilization of Health and Long-Term Care Services

Project No.: 18-P-98288/3-01
Period: March 1983 - March 1986
Funding: \$ 737,000
Grantee: Johns Hopkins University
School of Hygiene and Public Health
615 North Wolfe Street
Baltimore, Md. 21205
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: Johns Hopkins is evaluating an intervention project conducted at New York University Hospital, entitled "Cooperative Care" in which chronically ill Medicare beneficiaries and their care partners are trained in self-care techniques. The purpose of the project is to reduce the high rate of post-discharge rehospitalizations for certain chronic conditions (e.g., heart disease) through good home care monitoring. Cooperative Care, a 4-day inpatient education program, emphasizes the care partner's role in reinforcing patients to take their medication and to adhere to diet and exercise regimens.

Status: Since the beginning of the study, 480 patients plus 480 care partners have been randomly assigned to the experimental or control group. Approximately 80 percent of the experimental patients are transferred into Cooperative Care from New York University Hospital, and the other 20 percent are directly admitted to the program. Approximately 332 patients (plus their care partners) in the study have completed the first followup questionnaire (2 weeks), and more than 210 pairs have completed the 6-month followup questionnaire.

Trends in Pediatrician Participation in State Medicaid Programs

Project No.: 18-P-98265/5-01
Period: March 1983 - September 1984
Funding: \$ 195,796
Grantee: American Academy of Pediatrics
Department of Health Services Research
1801 Hinman Avenue
Evanston, Ill. 60204
Project Officer: Benson Dutton
Division of Reimbursement Studies

Description: The overall goal of the proposed study is to measure and analyze trends in physician participation in Medicaid and the Early and Periodic Screening, Diagnosis, and Treatment program in the 13 States that were studied by the Health Care Financing Administration in 1979. The study will also identify and recommend State-specific policy strategies for fostering the participation of primary care physicians in Medicaid, thereby promoting access of children to appropriate and efficient sites of preventive and acute care.

Status: The survey of physicians undertaken during the first year of this project has been completed. The completed questionnaires are being processed. Phone calls to nonrespondents are being made to gather information for the response analysis. Development of descriptive statistical reports, for panel and sample, for each of the 13 study States, and replication of 1979 multivariate analysis of determinants of pediatrician participation in Medicaid, has begun.

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